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ABSTRACT

This document seeks to inform administrators and clinicians about appropriate diagnosis and treatment approaches that will help ensure the development or enhancement of effective lesbian-, gay-, bisexual-, and transgender (LGBT)-sensitive programs. Serving as both a reference tool and program guide, it provides statistical and demographic information, prevalence data, case examples and suggested interventions, treatment guidelines and approaches, and organizational policies and procedures. Section one provides an introduction and includes information on sexual orientation, legal issues, and treatment approaches and modalities from a lesbian, gay, bisexual, and transgender standpoint. Section two, written for the practicing clinician, offers further information on clinical issues of LGBT clients; an introduction to strategies and methods for improving current services to LGBT individuals; and steps for starting LGBT-sensitive programs. Section three, developed for program administrators, provides an overview of the issues that need to be addressed when developing a LGBT program or when expanding current services for LGBT clients. It offers the data needed to build a strong foundation for a program, including an organizational mission and policies and procedures. Also provided are resources and strategies for working with managed care organizations and building alliances and cooperative arrangements to coordinate efforts on behalf of LGBT individuals. Appended are: Glossary of Terms; Acronyms; and Studies on LGBT Substance Abuse. (Contains 260 references.) (GCP)

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Foreword

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) is pleased to present *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*.

This publication was developed through a systematic and innovative process in which clinicians, researchers, program and administrative managers, policymakers, and other Federal, State, and independent experts were brought together for a series of intensive sessions. These individuals reviewed and discussed current administrative and clinical practices for treating substance-abusing lesbian, gay, bisexual, and transgender individuals and then wrote and edited the resulting document. The goal of this process was to improve and advance substance abuse treatment for a community of individuals whose health care needs are often ignored, denigrated, or denied.

This document seeks to inform administrators and clinicians about appropriate diagnosis and treatment approaches that will help ensure the development or enhancement of effective lesbian, gay, bisexual, and transgender (LGBT)-sensitive programs. Serving as both a reference tool and program guide, it provides statistical and demographic information, prevalence data, case examples and suggested interventions, treatment guidelines and approaches, and organizational policies and procedures.

This publication focuses on the two most important audiences for successful program development and implementation—clinicians and administrators. Section I provides an introduction for both audiences and includes information on sexual orientation, legal issues, and treatment approaches and modalities from a lesbian, gay, bisexual, and transgender standpoint. Section II is written for the practicing clinician. It offers further information on clinical issues of lesbian, gay, bisexual, and transgender clients; an introduction to strategies and methods for improving current services to LGBT individuals; and steps for starting LGBT-sensitive programs. Section III, developed for program administrators, provides an overview of the issues that need to be addressed when developing an LGBT program or when expanding current services for LGBT clients. It offers the data needed to build a strong foundation for a program, including an organizational mission and policies and procedures. It provides resources and strategies for working with managed care organizations and building alliances and cooperative arrangements to coordinate efforts on behalf of LGBT individuals so that members of the LGBT population can promote self-help programs within their own communities.

Besides increasing awareness of the need for LGBT-sensitive treatment services and helping all those involved in the treatment process become more aware of LGBT issues, this document also serves an important public health function. For example, the convergence of HIV, hepatitis, and substance abuse is a major concern that has not been adequately addressed in LGBT communities, especially

regarding the availability of vaccines for hepatitis A and hepatitis B. Educating LGBT people about these vaccines, the importance of vaccination, and strategies for preventing hepatitis C infection is a responsibility of all health care providers, not just substance abuse treatment professionals.

This publication is the result of the collaboration of many contributors, and CSAT gratefully acknowledges the dedication, time, talent, and hard work that the writers and reviewers have brought to this publication.

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Executive Summary

This publication presents information to assist providers in improving substance abuse treatment for lesbian, gay, bisexual, and transgender (LGBT) clients by raising awareness about the issues unique to LGBT clients. Sensitizing providers to these unique issues will, it is hoped, result in more effective treatment and improved treatment outcomes. Effective treatment with any population should be sensitive and culturally competent. Substance abuse treatment providers, counselors, therapists, administrators, and facility directors can be more effective in treating LGBT clients when they have a better understanding of the issues LGBT clients face. With this knowledge, treatment providers can reexamine their treatment approaches and take steps to accommodate LGBT clients.

Substance Abuse in the LGBT Community

Precise incidence and prevalence rates of substance use and abuse by LGBT individuals are difficult to determine for several reasons:

- Reliable information on the size of the LGBT population is not available.
- Epidemiologic studies on alcohol and drug abuse rarely ask about sexual orientation.
- Research studies cannot be compared because of inconsistent methodologies.

Studies indicate that, when compared with the general population, LGBT people are more likely to use alcohol and drugs, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later life. Some studies have found that approximately 30 percent of all lesbians have an alcohol abuse problem (Saghir et al., 1970; Fifield, DeCrescenzo & Latham, 1975; Lewis, Saghir & Robins, 1982; Morales & Graves, 1983). Studies that compared gay men and lesbians with heterosexuals have found that 20 to 25 percent of the gay men and lesbians are heavy alcohol users (compared with 3 to 10 percent of the heterosexuals studied) (Stall & Wiley, 1988; McKirnan & Peterson, 1989; Bloomfield, 1993; Skinner, 1994; Skinner & Otis, 1994; Hughes & Wilsnack, 1997). Marijuana and cocaine use has been found higher among lesbians than among heterosexual women (McKirnan & Peterson, 1989).

Although LGBT persons use and abuse alcohol and all types of drugs, certain drugs seem to be more popular in the LGBT community than in the majority community. Studies have found that gay men and men who have sex with men (MSM) are significantly more likely to have used marijuana, psychedelics, hallucinogens, stimulants, sedatives, cocaine, barbiturates, and MDMA (methylenedioxymethamphetamine) and are much more likely to have used "poppers" (Woody et al., 1999; Stall & Wiley, 1988). Party drugs, such as MDMA (also known as ecstasy or X-T-C), "Special K" or ketamine, and GHB (gamma hydroxybutyrate), are increasing in popularity among some segments of the LGBT population. Party drugs are often used during circuit parties and raves, and they can impair judgment and result in risky sexual behavior (Ostrow et al., 1993). Abuse of methamphetamine has increased dramatically in recent years (Drug Abuse Warning Network, 1998; Derlet & Heischober, 1990; Morgan et al., 1993; National Institute on Drug Abuse, 1994; Gorman, Morgan & Lambert, 1995; CSAT [Center for Substance Abuse Treatment], 1997b) among some segments of the LGBT community. HIV and hepatitis C infections are linked with methamphetamine use (CDC [Centers for Disease Control and

Prevention], 1995) and can lead to significant dependence and addiction. Some LGBT methamphetamine users inject the drug, putting them at risk for HIV, hepatitis B, and hepatitis C.

Sexual Orientation and Gender Identity

Understanding the appropriate terminology is essential to understanding LGBT clients. Sexual orientation, sexual behavior, gender identity, and gender role are different concepts. Sexual orientation is the affectional or loving attraction to another person. Heterosexuality is the attraction to persons of the opposite sex; homosexuality, to persons of the same sex; and bisexuality, to both sexes. Sexual orientation can be considered as ranging along a continuum from same-sex attraction only at one end of the continuum to opposite-sex attraction only at the other end. Sexual behavior, or sexual activity, differs from sexual orientation and alone does not define someone as an LGBT individual. Sexual identity is the personal and unique way that a person perceives his or her own sexual desires and sexual expressions.

Biological sex is the biological distinction between men and women. Gender is the concept of maleness and masculinity or femaleness and femininity. Gender identity is the sense of self as male or female and does not refer to one's sexual orientation or gender role. Gender role describes the behaviors that are viewed as masculine or feminine by a particular culture. Transgender individuals are those who conform to the gender role expectations of the opposite sex or those who may clearly identify their gender as the opposite of their biological sex. In common usage, transgender usually refers to people in the transsexual group that may include people who are contemplating or preparing for sexual reassignment. A transgender person may be sexually attracted to males, females, or both.

Sexual orientation and gender identity are independent variables in an individual's definition of himself or herself. How an individual learns to acknowledge, accept, and then act on a sexual orientation that is different from that of the majority is shaped by cultural, religious, societal, and familial factors. Transgender clients face a somewhat similar challenge in coming to terms with a gender identity that differs from their biological gender. An LGBT individual differs in the effect of sexual orientation on self-definition and in the degree of affiliation with other LGBT persons.

LGBT people and homosexual behavior are found in almost all cultures and throughout history. Homosexuality was considered a mental illness until 1973 when the American Psychiatric Association dropped the classification of homosexuality as a mental illness. It is now considered a normal variation of human sexual and emotional expression, allowing, it is hoped, a nonpathological and nonprejudicial view of the LGBT community.

Homophobia and Heterosexism

Having a general understanding of heterosexism and homophobia is important for substance abuse treatment providers working with LGBT individuals. Heterosexism and homophobia describe the forms of bigotry against LGBT people. Heterosexism resembles racism or sexism and denies, ignores, denigrates, or stigmatizes nonheterosexual forms of emotional and affectional expression, sexual behavior, or community. Homophobia is defined as the irrational fear of, aversion to, or discrimination against LGBT behavior or persons. Internalized homophobia describes the self-loathing or resistance to accepting an LGBT sexual orientation and is an important concept in understanding LGBT clients.

It is likely that all substance abuse treatment programs have LGBT clients, but staff members may not realize that they are treating

LGBT clients. Most treatment programs do not ask about sexual orientation, and many LGBT people are afraid to speak openly about their sexual orientation or identity. LGBT clients cannot anticipate the reaction they will receive when mentioning their sexual orientation.

How Heterosexism Contributes to Substance Abuse

Heterosexism can affect LGBT people by causing internalized homophobia, shame, and a negative self-concept (Neisen, 1990, 1993). Some LGBT individuals may resort to substance abuse to cope with the negative feelings. Counselors and clients should recognize that these effects result from prejudice and discrimination and are not a consequence of one's sexuality. It is not surprising to find that many LGBT individuals in therapy report feeling isolated, fearful, depressed, anxious, and angry and have difficulty trusting others. It is argued that the stigma and resulting tension of being a member of a marginalized community such as the LGBT community cause some members of the marginalized community to manage these additional stressors by using mind-altering substances. Substance use, especially alcohol use, is a large part of the social life of some segments of the LGBT community.

Cultural Issues

Culturally sensitive treatment often results in more effective treatment. A lively debate in the LGBT community continues about what comprises LGBT culture. LGBT people are from all cultural backgrounds, ethnicities, and racial groups; can be any age; can have attained any educational or income level; and live in all geographic areas in the United States.

The size of the LGBT community is not known. Reliable data are difficult to obtain. Michaels (1996) thoroughly analyzed the limited available data and estimated that, in the United States, 10 percent of men and 5 percent of women report same-gender sexual behavior since puberty; 8 percent of men and 7.5 percent of women report same-gender desire; and 3 percent of men and 1 percent of women report a homosexual or bisexual identity. The data on the number of transgender people are more limited. In addition to understanding a client's ethnic background, counselors should keep in mind how the client's culture views LGBT individuals and the effect this viewpoint has on the client. Each ethnic minority group has norms and values about LGBT members and behavior. Providers may be helpful to a client if they remember these multilayered, and sometimes opposing, influences on the client. For the LGBT person from an ethnic or racial minority, coping with one's sexual orientation takes place amid a tangle of cultural traditions, values, and norms. LGBT persons of color cope with trying to fit into the gay and lesbian communities in the face of racism and discrimination. For some, the added burden of these issues makes finding a comfortable place in society even more complex and difficult. Major ethnic minority groups in the United States react differently to issues of sexual orientation. It is important for the provider to assess how an LGBT client from a minority group feels about his or her culture. Some may be alienated from their culture, whereas others may be supported by it.

Legal Issues

Although Federal and a number of State statutes protect recovering substance abusers from many forms of discrimination, LGBT individuals are not afforded the same protections in many areas of the country. Disclosure of one's sexual orientation can lead to employment problems or the denial of housing and social services. LGBT individuals may lose custody of their children if their sexual orientation becomes known during a custody dispute. Even in those States that have enacted statutes prohibiting discrimination on the basis of sexual orientation, LGBT

individuals have sometimes been denied protection. LGBT individuals regard protecting information about their sexual orientation and substance abuse histories as critically important. Programs that treat this population must be particularly sensitive about maintaining clients' confidentiality, because the consequences of an inappropriate disclosure can be devastating. Programs can safeguard information about clients' substance abuse histories and sexual orientation status by:

- Respecting clients' confidentiality and establishing a written policy that ensures that information about their sexual orientation is confidential and that prohibits disclosure of such information to anyone outside the program without their consent
- Cautioning clients to think carefully about how self-disclosure information will be received and whether their privacy will be respected before disclosing their sexual orientation to others
- Educating staff members and clients about regulations affecting LGBT persons in their jurisdiction
- Encouraging clients to conduct a legal inventory of their employment, marital, and parental statuses and assess what steps they might take to protect themselves and their rights.

Treatment Accessibility, Modalities, and the Continuum of Care

Substance abuse treatment for an LGBT individual is the same as that for other types of clients and primarily focuses on stopping the substance abuse that interferes with the well-being of the client. It differs in the need for the client and counselor to address the client's feeling about his or her sexual identity and the impact of homophobia and heterosexism. Even if the LGBT client is candid about his or her identity, he or she may be harboring the effects of society's negative attitudes, which can result in feelings of doubt, confusion, fear, and sorrow (Diamond-Friedman, 1990). The client may have had problems in traditional health care systems and may distrust health care professionals, requiring extra sensitivity from substance abuse treatment providers (Mongeon & Ziebold, 1982).

Accessibility

Due to homophobia and discrimination against LGBT individuals, some may find it difficult or uncomfortable to access treatment services. Substance abuse treatment programs are often not equipped to meet the needs of this population. Heterosexual treatment staff members may be uninformed about LGBT issues, may be insensitive to or antagonistic toward LGBT clients, or may falsely believe that sexual identity causes substance abuse or can be changed by therapy. These beliefs by providers become barriers to treating the LGBT client.

Modalities

Some issues arise when treating LGBT clients using typical treatment modalities for groups, couples, or families. Groups should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns. Other clients in therapy may have negative attitudes toward LGBT clients. Staff members should ensure that LGBT clients are treated in a therapeutic manner and should tell other clients that homophobia will not be tolerated. It should be the LGBT client who decides whether to discuss issues relating to his or her sexual orientation in mixed groups. Providing individual services eliminates the mixing of heterosexual and LGBT clients in treatment groups and decreases the likelihood that heterosexism/homophobia will become an issue. However, in a mixed group led by

trained and culturally competent staff members, LGBT clients may have a powerful healing experience by gaining acceptance and support from non-LGBT peers. Family and couple counseling can be difficult because of alienation owing to the client's sexual identity. Often, LGBT couples are not treated with sensitivity, and support is not offered to partners.

Levels of Care

LGBT substance abusers should be assessed to determine the range of services and levels of care they require. Knowledge of the type and amount of a drug used by a client, the danger of a medically complicated withdrawal, the difficulty of withdrawal, and the impact of social and psychological stressors helps a counselor determine the level of care a client needs. Whatever the planned treatment, the level of care should match the client's needs.

Continuum of Care

The continuum of care refers to services provided in addition to program services and services received after discharge such as followup and monitoring activities, outreach, recruitment, and retention. The types of services offered for LGBT clients may differ because of the health status of the clients or their partners; their living arrangements; the type and stability of their employment; their level of comfort about their sexual orientation; and their previous experience with service providers and service systems.

Discharge Planning

Specific concerns related to discharge planning include an analysis of the client's social support, living arrangements or environments, employment status, type of employment, and ongoing issues related to his or her sexual orientation or identity. Possible support systems include the client's family of origin and family of choice, partner, friends, and others and should focus on individuals who support his or her efforts to maintain recovery. LGBT clients may live in an environment that is not conducive to recovery (e.g., they have a partner or roommate who is actively using or their social life revolves around bars and parties).

The Coming Out Process

The term "coming out" refers to the experiences of some, but not all, gay men and lesbians as they explore their sexual identity. There is no correct process or single way to come out, and some LGBT persons do not come out. The process is unique for each individual, and it is the choice of the individual. Several stages have been identified in the process: identity confusion, comparison, tolerance, acceptance, pride, and identity synthesis (Cass, 1979).

When developing a plan and treating LGBT clients, providers should consider which stage the client is in. To be most helpful, counselors need to recognize a client's comfort level with his or her feelings about his or her sexual identity and treat the client accordingly. A client who is uncomfortable with his or her sexual identity may not want to attend LGBT Alcoholics Anonymous (AA) meetings or discuss feelings about sexual orientation. However, these meetings could be helpful for a client who is more comfortable with his or her sexual identity. A provider may do harm if he or she forces openness by questioning a client's sexuality before the client is ready. As with many decisions, a provider can best serve his or her clients by assuming little and gauging the best form of care for reducing the client's fears and anxiety.

Families of Origin and Families of Choice

Providing support for LGBT clients and their families is a significant element of substance abuse treatment. Like other clients, LGBT individuals in treatment are involved in

multidimensional situations and come from diverse family backgrounds. A family history and a review of the dynamics of the family of origin are part of a thorough biopsychosocial assessment. Questions should be asked with sensitivity. An LGBT client may have unresolved issues with his or her family of origin stemming from the family's reaction to the disclosure of his or her sexual identity. A negative and intolerant reaction can have a devastating effect on the LGBT individual. Family dynamics are important in working with LGBT individuals, and counselors can put their understanding of these dynamics to work in counseling LGBT clients and their families. An LGBT client may have close connections to what is called a family of choice—a legal spouse or unrelated individuals who support and care about the client. A support group that works with families of origin is known as PFLAG (Parents, Families and Friends of Lesbians and Gays).

Substance abuse counselors need an understanding of the dynamics of LGBT interpersonal relationships. This understanding includes awareness of the internal and external problems of same-sex couples and the diversity and variety of relationships in the LGBT community. Although many individuals have a life partner, others are single or in nontraditional arrangements. Providers need to be aware of their own biases when working with individuals who find themselves outside the cultural norm of a heterosexual, monogamous, and legally sanctioned marriage.

Many LGBT individuals are parents and have children from a heterosexual marriage, have adopted children, or have children through some other means. Substance abuse treatment providers should expect to work with increasingly more LGBT clients who are parents, either as part of a couple or as single parents, and should consider parenting issues during treatment and discharge planning.

Clinical Issues

Lesbians, gay men, bisexuals, and transgender individuals have unique difficulties. Unless counselors carefully explore each client's individual situation and experiences, they may miss important aspects of the client's life, which may affect recovery. Many factors contribute to the prominent role of substance use and abuse in LGBT people. Legal prohibitions against LGBT behavior and discrimination have limited LGBT people's social outlets to bars, private homes, or clubs where alcohol and drugs often play a prominent role. Growing up in a society that says they should not exist and certainly should not act on their sexual feelings, LGBT clients may have internalized this homophobia. Relapse prevention requires an understanding of the social life many gay men will return to after discharge from treatment, whether as part of the singles circuit party group or as part of a same-sex couple raising children. For lesbians, the party scene is generally not as intense.

LGBT people may be victims of antigay violence and hate crimes such as verbal and physical attacks. Some victims may turn to alcohol or drug use. It is important that substance abuse counselors obtain training and education about interpersonal violence and stigmatized client populations.

Clinical Issues With Lesbian Clients

Lesbians resemble other women in that their patterns of substance use vary. However, fewer lesbians than heterosexual women abstain from alcohol; rates of reported alcohol problems are higher for lesbians than for heterosexual women; and drinking, heavy drinking, and problem drinking show less decline with age among lesbians than among heterosexual women (Hughes & Wilsnack, 1997). Risk factors for abusing alcohol

include relying on women's bars for socializing and peer support; the negative effects of sexism and heterosexism; additional stressors related to coming out or "passing" as heterosexual; and the effects of trauma from violence or abuse. The traumas experienced by some lesbians may affect their behavior and emotional state. One study reported that 21 percent of lesbians were sexually abused as children and 15 percent were abused as adults (Bradford, Ryan & Rothblum, 1994).

Clinical Issues With Gay Male Clients

In spite of growing acceptance of gay people, social outlets for gay men still tend to be limited. The "gay ghetto," the section of town where gay people feel comfortable, usually is identified by the presence of gay bars. The number of gay coffee shops, bookstores, and activities that do not involve alcohol and drug use is increasing, but gay bars and parties that focus on alcohol and drug use are still very visible elements of gay social life.

HIV/AIDS continues to be a major factor in gay male life. The percentage of HIV-infected people in the United States who are gay has steadily dropped. But many gay men in treatment may be HIV seropositive, have AIDS, or have a sense of loss from losing friends. For some gay men, sex and intimacy may be disconnected. Substance use allows them to act on suppressed or denied feelings but makes it harder to integrate intimacy and sex.

In general, the stereotypical American male can be described as powerful, independent, emotionally reserved, and career motivated. Males who do not fit this stereotype may have trouble fitting in or feel uncomfortable. Many gay men do, however, grow up different from their heterosexual peers, and some have traits more commonly associated with females. Being effeminate is sometimes condemned in the gay community, and this characteristic adds to gay men's shame.

Clinical Issues With Bisexual Clients

Bisexual identity is not necessarily defined by sexual behavior. An assessment of a self-identified bisexual client includes sexual behavior and identity issues and the range of psychosocial issues that may complicate substance abuse treatment. The current conceptualization of bisexuality is that it is a sexual orientation. Providers may have biases about bisexuals, believing that they are psychologically or emotionally damaged, are developmentally immature, or have a borderline personality disorder, with changing sexual behavior manifesting as a symptom of poor impulse control or acting-out behavior. Bisexuals may feel alienated not just from the heterosexual majority but also from the lesbian and gay community. Internalized biphobia may result in a struggle toward self-acceptance.

Clinical Issues With Transgender Clients

The psychiatric model views transsexualism as psychopathological and classifies it as a gender identity disorder. Many in the transgender community disagree with this classification.

The little research available about the prevalence of substance abuse in the transgender community suggests extremely high rates. Substance abuse among transgender people can involve multiple patterns of abuse and multiple problems; treatment must be multimodal to correspond to a client's particular pattern of abuse (Lewis, Dana & Gregory, 1994).

Issues in substance abuse treatment for transgender clients include societal and internalized transphobia, violence, discrimination, family problems, isolation, lack of educational and job opportunities, lack of access to health care, and clients' low self-esteem. Many transgender people have had negative experiences with providers of health care, and they may be distrustful of providers.

Hormone therapy is an often overlooked clinical issue. Hormone treatment is a standard medical practice for transsexuals, and clients may need assistance in maintaining regular, legally prescribed hormone therapy while in treatment for substance abuse. It is important that both the clinician and the client understand that hormone therapies can affect mood, especially when taken improperly. Transgender clients may face an additional risk from using "street" or "black market" hormones. Because testosterone must be injected, obtaining or using needles may be relapse triggers for clients in early recovery.

Transgender clients may face issues with inpatient treatment and placement in housing and shelters. Logistics such as rest room use and sleeping arrangements need to be sensitive to both transgender clients and other clients. Evidence suggests that transgender individuals have a higher rate of exposure to violence and discrimination than lesbians and gay men, and such experiences can influence a transgender client's ability to complete and maintain successful recovery from substance abuse. Some transgender clients have been prostitutes or sex workers, resulting in clinical issues that can also block recovery if they are not adequately addressed.

Cases involving transgender individuals illustrate the need for staff to ask open-ended questions regarding gender and sexual orientation. In this way, those who are or are perceived to be transgender persons are given the opportunity to disclose this at their own comfort level. These types of questions also allow those whose transgender status is invisible to disclose their status to the counselor if they sense that he or she might have an understanding of transgender issues.

Clinical Issues With Youth

The available research on LGBT youth has focused on lesbian and gay male adolescents; little information is available on bisexual identity development or transgender youth. Some studies of gay youth show high rates of alcohol and drug use (Remafedi, 1987; Rotherman-Borus, Hunter & Rosario, 1994), whereas other studies show rates that are comparable with those of adolescents in general (Boxer, 1990; Bradford & Ryan, 1987; Herdt & Boxer, 1993). LGBT youth use alcohol and drugs for many of the same reasons as their heterosexual peers: to experiment and assert their independence, to relieve tension, to increase feelings of self-esteem and adequacy, and to self-medicate for underlying depression or other mood disorders. LGBT youth, however, may be more vulnerable as a result of the need to hide their sexual identity and the ensuing social isolation. As a result, they may use alcohol and drugs to deal with stigma and shame, to deny feelings for persons of the same sex, or to help them cope with ridicule or antigay violence. LGBT youth have the same developmental tasks as their heterosexual peers, but they also face additional challenges in sorting out their sexual identity.

The age at which identity development and coming out occurs is decreasing, with most adolescents' initial awareness of feelings for someone of the same sex occurring at age 10; first experiences with someone of the same sex at ages 13 to 15; and initial self-identification as lesbian or gay at ages 15 to 16 (D'Augelli & Herschberger, 1993; Herdt & Boxer, 1993; Rosario et al., 1996). Adolescents may not have developed the coping strategies that LGBT adults have to contend with the added stressors (Hunter & Mallon, 1999). LGBT youth are at high risk for antigay violence such as physical attacks, verbal and physical abuse, and harassment (D'Augelli & Dark, 1995; Dean, Wu & Martin, 1992). Youth of color and those who are openly or stereotypically gay are more likely to be

victimized, and anecdotal reports suggest that transgender youth may be at the greatest risk.

Related Health Issues

An LGBT client may face a variety of additional health problems when entering treatment. LGBT clients in recovery have similar health concerns and face many of the same physical and mental health crises as other clients in recovery.

Many people who abuse substances have co-occurring mental health disorders, such as affective disorders, eating disorders, or other psychiatric illnesses. Substance abuse clouds good judgment and contributes to dangerous behaviors that can lead to illness, such as HIV/AIDS, sexually transmitted diseases (STDs), hepatitis, and injuries. People who abuse substances may have neglected their health, and some may have been the victims of domestic violence or hate crimes resulting in posttraumatic stress disorder. When considering these factors, providers of substance abuse treatment for LGBT clients should, as with any client, screen for other health problems—for possible co-occurring mental health disorders, poor nutrition, poor dental care, liver disease, STDs, HIV/AIDS, and sexual abuse. In this way, substance abuse treatment providers can assist their LGBT clients in accessing appropriate medical care and treatment for their health and mental health concerns.

LGBT individuals have been marginalized by some health professionals, who historically labeled an LGBT sexual orientation deviant or pathological. As a result, LGBT individuals may not disclose their sexual orientation to health care providers (Cochran & Mays, 1988), and many LGBT individuals, particularly transgender individuals, may be reluctant to use mainstream health care services. Their hesitation to seek health care may result in late diagnosis and poor treatment outcomes. The substance abuse treatment provider may need to help LGBT clients overcome discomfort in seeking health care when in recovery.

Gay and bisexual men who are sexually active with multiple partners are at risk for contracting STDs, HIV/AIDS, and hepatitis A and hepatitis B through sexual contact. Hepatitis C also may be spread by sexual contact, although transmission via infected needles is probably a far more significant route and is of concern to all injection drug users. All clients should be screened for hepatitis B and hepatitis C and referred for hepatitis A and hepatitis B vaccinations.

Knowledge about health concerns unique to lesbian and bisexual women is limited. Alcoholic women have more fatty liver disease, alcoholic hepatitis, cirrhosis, and osteoporosis than nonalcoholic women (Woolf, 1983). Many lesbians have had heterosexual contacts and are at risk for both pregnancy and STDs (O'Hanlan, 1995). Lesbian and bisexual women who use injectable drugs are at high risk for hepatitis B, hepatitis C, and HIV/AIDS and should be screened for these diseases. Some lesbian and bisexual women are sex workers and have been exposed to STDs, HIV, and trauma. Transgender individuals have many health concerns. One study showed a 35-percent HIV prevalence rate among male-to-female (MTF) transgender individuals and a 65-percent HIV prevalence rate among African-American MTF transgender individuals. Both MTF and FTM (female-to-male) transgender individuals encounter risks related to taking hormones.

Interpersonal Violence in the LGBT Community

Little research has been done on the relationship between substance abuse and interpersonal violence in the LGBT community, but it is estimated that interpersonal violence occurs at the same rate in same-sex relationships as in heterosexual relationships (Island &

Letellier, 1991; Lobel, 1986). Rates of violence in same-sex relationships range from 8 to 46 percent (Elliot, 1996). As with all their clients, practitioners should assess their LGBT clients for evidence of involvement in interpersonal violence and act appropriately.

Counselor Competence in Treating LGBT Clients

LGBT clients can be found in all types of treatment settings: residential, intensive outpatient, outpatient, crisis intervention, and the criminal justice system.

In the counseling competencies model, a counselor should respect the client and his or her frame of reference; recognize the importance of cooperation and collaboration with the client; maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with client characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and be nonjudgmental and respectfully accepting of the client's cultural, behavioral, and value differences. These best-practice methods are critical when working with LGBT clients.

In the counseling competencies model, a counselor is responsible for self-monitoring, obtaining proper supervision, and adhering to professional and ethical standards. Establishing the proper ethos of care for LGBT clients requires that counselors monitor themselves and be aware of and work through their feelings about LGBT clients. Counselors must be aware of countertransference, the process of counselors seeing themselves in their clients, overidentifying with their clients, meeting their personal needs through their clients, or reacting to a client because of their own unresolved personal conflicts (Corey, 1991).

Administrative Issues

A substance abuse treatment program's commitment to promote sensitive care for LGBT clients can be included in its mission statement and administrative policies and procedures. Providing staff training and education on LGBT issues helps increase awareness of the issues. A program's policies and procedures can address the inclusion of LGBT issues in its advertising, community relations, administrative and personnel policies, training, and program design.

Adding LGBT issues to a quality improvement program may be helpful as well. To furnish quality treatment, providers should evaluate their programs and collect appropriate demographic data to establish baseline information about LGBT clients. They should design and implement appropriate client satisfaction measures that provide specific feedback about how well their organization is serving its LGBT clients. Providers should develop better LGBT-specific outcome data. The data should include the numbers of clients served, overall satisfaction results, and treatment outcomes among identified LGBT clients as compared with the general treatment population.

Training and Education

Training providers to sensitively serve LGBT individuals may improve treatment outcomes. Some options include sexual orientation sensitivity training to promote better understanding of LGBT issues, LGBT-specific training, and educational programs to ensure that quality care is provided. The comfort level, experience, and competence of staff serving LGBT individuals should be assessed before and after training.

Alliances and Networks

A substance abuse treatment program seeking to improve care to LGBT individuals has many

allies throughout both the health care community and the LGBT community. The program administrator who effectively identifies and works with his or her allies will have taken an important step toward ensuring that his or her program is successful. This cooperation will be particularly important in building local support to serve LGBT clients and to work effectively with managed care organizations.

For managed care and other health care provider networks to improve LGBT sensitivity, their provider panels can include LGBT providers and LGBT-sensitive providers. LGBT programs may want to join provider networks to ensure provision of culturally competent services.

Conclusion

Because each client brings his or her unique history and background into treatment, furthering our understanding of individuals different from ourselves helps ensure that clients are treated with respect, while improving the likelihood of effective substance abuse treatment interventions. It is hoped that the information in this publication helps providers improve their ability to provide competent and effective treatment. A substance abuse treatment provider who is knowledgeable about the unique needs of LGBT clients can enhance treatment. A provider who understands and is sensitive to the issues surrounding sexual and gender identity, homophobia, and heterosexism can help LGBT clients feel comfortable and safe while they confront their substance abuse and start their journey of recovery. It is hoped that this volume will assist administrators and clinicians in forming a better understanding of LGBT people, their problems with substance abuse, and the unique challenges they face and that the knowledge providers gain from it about designing programs for LGBT clients will be used to create a more comfortable treatment environment.

SECTION I:
OVERVIEW

Chapter 1 An Overview for Providers Treating LGBT Clients

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What providers will learn from this chapter:

- The epidemiology of substance abuse among the LGBT population
- The types of substances abused
- Definitions of key terms
- Characteristics of LGBT individuals
- How differences in LGBT life experiences may shape the substance abuse issues
- Life cycle issues for LGBT individuals

Introduction

For substance abuse treatment providers to deliver skilled care to lesbian, gay, bisexual, and transgender (LGBT) clients, they need to be aware of issues specific to the LGBT community. This chapter presents an overview of the use and abuse of substances in the LGBT community and a brief introduction to the concepts of gender identity, sexual orientation, homophobia, and heterosexism.

Substance Use and Abuse in the LGBT Community

In a discussion of the epidemiology of substance use and abuse among LGBT individuals, the following two questions are of interest to providers:

- What is the epidemiology of substance use and abuse among LGBT individuals?
- Do LGBT individuals use or abuse more substances than heterosexuals or the general population?

Epidemiology is the study of the patterns of disease and health problems in populations and the factors that influence these patterns. **Prevalence** refers to the number of people in a given population who are affected by a particular disease at a certain time; it is frequently expressed in percentages. **Incidence** refers to the number of new

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cases of a disease or condition, such as alcoholism or drug abuse, in a given population over a specified time (such as a year).

Rates of substance use and abuse vary from population to population. The numerous reasons for the varying rates include biological, genetic, psychological, familial, religious, cultural, and historical circumstances. The LGBT population is similar to the general population in that numerous factors predispose its members to substance abuse. However, some clinicians argue that the additional stigma and resulting tension of being a member of a marginalized community such as the LGBT community cause some members of the marginalized community to seek to manage these additional stressors by using mind-altering substances.

The precise incidence and prevalence rates of substance use and abuse by LGBT individuals have been difficult to determine for several reasons. Reliable information on the size of the LGBT population is not available. Scientific studies of LGBT individuals' substance abuse do not always clearly define the difference between substance use and substance abuse, making it difficult to compare studies. Many studies have methodological flaws, such as the use of convenience samples that only infer or estimate substance abuse among the LGBT population. However, several promising studies are under way that, it is hoped, will provide additional information. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) will continue to report the results of these studies as they are completed.

To provide background information for this publication, the authors conducted a review of the epidemiological literature, and 16 studies were chosen to highlight the extent of substance use or abuse problems in the LGBT population. The table in appendix D, Studies on LGBT Substance Abuse, presents a comparison of the studies. Studies were included if they focused on the LGBT population and substance abuse but did not focus primarily on the human immunodeficiency virus (HIV). These studies are considered classics and have been cited in numerous articles about LGBT individuals' substance abuse. The summary is by no means exhaustive; however, it provides the context for exploring the issue and has implications for future research.

Publication dates of articles about the selected studies range from 1970 to 2000. Of the 16 studies, 10 focused primarily on substance abuse in the lesbian population, 3 focused on both lesbians and gay men, 1 focused exclusively on gay men, 1 focused exclusively on men who have sex with men (MSM), and 1 focused on transgender individuals. Eleven of the studies used convenience samples, and five used population-based data. Most of the studies reported on alcohol use.

These studies generally state that gay men and lesbians have greater substance abuse problems than non-LGBT men and women. In seven studies, comparisons between the LGBT population and the heterosexual population could not be made. Studies by Saghir and colleagues (1970); Fifield, DeCrescenzo, and Latham (1975); Lewis, Saghir, and Robins (1982); and Morales and Graves (1983) found that approximately 30 percent of all lesbians have an alcohol abuse problem. Studies that compared gay men or lesbians with heterosexuals (Stall & Wiley, 1988; McKirnan & Peterson, 1989; Bloomfield, 1993; Skinner, 1994; Skinner & Otis, 1996; Hughes & Wilsnack, 1997) found that gay men and lesbians were heavier substance and alcohol users than the general or heterosexual population. From these studies, it is clear that substance abuse treatment is needed and that providers need to know more about this community to provide competent treatment.

Types of Substances Abused

Over the past several years, the concerns about the epidemic of HIV-related conditions have led to an increased number of studies of both gay and bisexual men and injection drug users. Although LGBT persons use and abuse alcohol and all types of drugs, certain drugs seem to be more popular in the LGBT community than in the majority community.

Woody and colleagues (1999) compared a convenience sample of MSM at high risk for HIV who participated in a vaccine preparedness study with a nationally representative sample of men from the 1995 National Household Survey on Drug Abuse (NHSDA). The study found that these MSM were 21 times more likely to use nitrite inhalants. They were also much more likely (four to seven times) to use hallucinogens, stimulants, sedatives, and tranquilizers than the men in the NHSDA sample. The study also found that weekly use by this MSM sample was 2 times more likely for marijuana, cocaine, and stimulants and 33 times more likely for inhalant nitrites.

A study by Cochran and Mays (2000) found that people with same-sex partners were more likely to use substances than were people with opposite-sex partners. Closer examination of the data (Cochran et al., in press) comparing MSM with heterosexual men and comparing lesbians with heterosexual women showed little difference between MSM and heterosexual male substance abuse but showed that rates of alcohol use were much higher for lesbians than for heterosexual women. For example, lesbians used alcohol twice as often in the past month, were five times more likely to use alcohol every day, were more than twice as likely to get intoxicated, and were four times more likely to get intoxicated weekly than heterosexual women.

Another study of lesbians using self-reported data stated that rates of alcohol use in the lesbian population were higher than those in the general population, but not as high as rates in other studies, and that the most significant predictor of alcohol use was reliance on bars as a primary social setting (Heffernan, 1998).

Designer Drug Use

Abuse of methamphetamine, also known as meth, speed, crystal, or crank, has increased dramatically in recent years (Drug Abuse Warning Network, 1998; Derlet & Heischober, 1990; Morgan et al., 1993; National Institute on Drug Abuse, 1994; Gorman, Morgan & Lambert, 1995; CSAT, 1997b), particularly among gay men but also among male-to-female (MTF) transgender individuals and, increasingly, among some groups of lesbians. What makes the current epidemic so disconcerting is its relationship to the HIV epidemic (Ostrow, 1996; Gorman et al., 1997).

Amphetamines and methamphetamine currently are the most popular synthetic stimulants in the United States, and abuse of them can lead to significant dependence and addiction. The drugs may be drunk, eaten, smoked, injected, or absorbed rectally. They have a half-life of approximately 24 hours. They work by releasing neurotransmitters, and users suffer the same addiction cycle and withdrawal reactions as those suffered by crack cocaine users. These substances increase the heart rate, blood pressure, respiration rate, and body temperature. They cause pupil dilation and produce alertness, a sense of euphoria, and increased energy. After prolonged use, users often experience severe depression and sometimes paranoia. They may also become belligerent and aggressive.

Methamphetamine use appears to be integral to the sexual activities of a certain segment of gay men, especially in some urban communities. The so-called party drugs, such as MDMA (methylenedioxymethamphetamine) (also known as ecstasy or X-T-C),"Special K" or

ketamine, and GHB (gamma hydroxybutyrate), are increasingly popular at dances and celebrations, such as circuit parties and raves.

MDMA is a synthetic drug with hallucinogenic and amphetamine-like properties. The effects are reminiscent of lysergic acid diethylamide-25 (LSD). Ketamine, a white crystalline powder that is soluble in water and alcohol, is a dissociative anesthetic, a synthetic drug that produces hallucinations, analgesia, and amnesia and can cause euphoria. Users can experience impaired thought processes, confusion, dizziness, impaired motor coordination, and slurred speech. Liquid X (GHB) possesses euphoric properties, and overdoses can cause electrolyte imbalances, decreased respiration, confusion, and hypertension, as well as seizure-like activity and vomiting.

Party drugs can impair judgment and increase sexual risk taking. Research has shown a connection between use of nitrite and high-risk sexual behavior (Ostrow et al., 1993), and there is compelling evidence that HIV and hepatitis C infections are linked with methamphetamine use. Studies in several cities indicate that gay and bisexual men who used speed, alone or in combination with other drugs, appear to have much higher seroprevalence rates than either heterosexual injection drug users or gay and bisexual men who do not use these drugs (Harris et al., 1993; Diaz et al., 1994; Gorman, 1996; CDC [Centers for Disease Control and Prevention], 1995; Hays, Kegeles & Coates, 1990; Waldorf & Murphy, 1990; Paul, Stall & Davis, 1993; Paul et al., 1994). This finding is particularly apparent for individuals who inject these drugs and who share needles or injecting equipment. Although most LGBT meth users probably snort, ingest, or smoke the drugs, a sizable number also report histories of injection drug use. Within the substance-abusing population in general, and the LGBT population in particular, injection drug users represent an often hidden and stigmatized group. Public health efforts have targeted mostly heterosexual injection drug users of heroin. A number of injection drug users inject methamphetamine, and a number of these are LGBT individuals.

Information on the needle hygiene of methamphetamine users or LGBT injection drug users is lacking. Some HIV-positive individuals appear to be self-medicating for depression or specific HIV-related symptoms by using methamphetamine because it reduces lethargy, raises libido, and can be an antidepressant. Mixing these drugs can be dangerous, and some deaths have been documented from using party drugs while taking protease inhibitors.

Definition of Terms and Concepts Related to LGBT Issues

Understanding how certain terms are used is essential to understanding homosexuality. It is important to recognize the difference between sexual orientation and sexual behavior as well as the differences among sexual orientation, gender identity, and gender role.

Sexual orientation may be defined as the erotic and affectional (or loving) attraction to another person, including erotic fantasy, erotic activity or behavior, and affectional needs. **Heterosexuality** is the attraction to persons of the opposite sex; **homosexuality**, to persons of the same sex; and **bisexuality**, to both sexes. Sexual orientation can be seen as part of a continuum ranging from same-sex attraction only (at one end of the continuum) to opposite-sex attraction only (at the other end of the continuum).

Sexual behavior, or sexual activity, differs from sexual orientation and alone does not define someone as an LGBT individual. Any person may be capable of sexual behavior with a person of the same or opposite sex, but an individual knows his or her longings—erotic

and affectional—and which sex is more likely to satisfy those needs.

It is necessary to draw a distinction between sexual orientation and sexual behavior. Not every person with a homosexual or bisexual orientation, as indicated by his or her fantasies, engages in homosexual behavior. Nor does sexual behavior alone define orientation. A personal awareness of having a sexual orientation that is not exclusively heterosexual is one way a person identifies herself or himself as an LGBT person. Or a person may have a sexual identity that differs from his or her biological sex—that is, a person may have been born a male but identifies and feels more comfortable as a female. Sexual orientation and gender identity are two independent variables in an individual's definition of himself or herself.

Sexual identity is the personal and unique way that a person perceives his or her own sexual desires and sexual expressions. Biological sex is the biological distinction between men and women.

Gender is the concept of maleness and masculinity or femaleness and femininity. One's **gender identity** is the sense of one's self as male or female and does not refer to one's sexual orientation or gender role. **Gender role** refers to the behaviors and desires to act in certain ways that are viewed as masculine or feminine by a particular culture.

A culture usually labels behaviors as masculine or feminine, but these behaviors are not necessarily a direct component of gender or gender identity. It is common in our culture to call the behaviors, styles, or interests shown by males that are usually associated with women "effeminate" and to call the boys who behave this way "sissies." Women or girls who have interests usually associated with men are labeled "masculine" or "butch," and the girls are often called "tomboys."

Transgender individuals are those who conform to the gender role expectations of the opposite sex or those who may clearly identify their gender as the opposite of their biological sex. In common usage, transgender usually refers to people in the transsexual group that may include people who are contemplating or preparing for sexual reassignment surgery—called preoperative—or who have undergone sexual reassignment surgery—called postoperative. A transgender person may be sexually attracted to males, females, or both.

Transvestites cross dress, that is, wear clothes usually worn by people of the opposite biological sex. They do not, however, identify themselves as having a gender identity different from their biological sex or gender role. The motivations for cross dressing vary, but most transvestites enjoy cross dressing and may experience sexual excitement from it. The vast majority of transvestites are heterosexual, and they usually are not included in general discussions about LGBT people.

Gender identity disorder (GID) was introduced in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV) (American Psychiatric Association, 1994). Although GID is listed as a mental illness, most clinicians do not consider individuals who are confused or conflicted about their biological gender and their personal sense of their gender identity to be mentally ill. Considerable work needs to be done to augment the small amount of research available on the development of a transgender identity—that is, how a person becomes aware of a sexual identity that does not match his or her biological sex or gender role.

Estimates of the Number of LGBT Individuals

The true number of people who identify themselves as LGBT individuals is not known. Because of a lack of research focusing on the

LGBT population and the mistrust that makes many LGBT people afraid to be open about their identity, reliable data are difficult to obtain. The popular estimate that 10 percent of the male population and 5 to 6 percent of the female population are exclusively or predominately homosexual is based on the Kinsey Institute data (Kinsey, Pomeron & Martin, 1948; Kinsey et al., 1953) addressing sexual behavior. Kinsey proposed the Kinsey Scale, a continuum that rated sexual behavior on a scale from zero to six. Zero represented exclusive heterosexual behavior and six represented exclusive homosexual behavior. The survey reported that 37 percent of American men had at least one homosexual experience after adolescence; 5 to 7 percent had bisexual experiences but preferred homosexual ones; and 4 to 5 percent had homosexual experiences exclusively.

These data illustrate how widespread male homosexual behavior is, not necessarily the number of gay men. The same research indicated that the majority of those surveyed reported behavior in a range Kinsey termed bisexual. Again, the classification is based only on reported behavior. For many minority populations, bisexuality—but not homosexuality—is acceptable (or at least admittable on surveys). For example, in the 1989 Centers for Disease Control and Prevention 8-year review of acquired immunodeficiency syndrome (AIDS) cases among gay or bisexual men, 54.2 percent of African Americans were reported to be bisexual, 44.2 percent of Hispanics were reported to be bisexual, and 11.3 percent of Caucasians were reported to be bisexual.

Michaels (1996) thoroughly analyzed the limited available data and concluded that determining prevalence rates of sexual orientations is extremely difficult because the data are widely disparate. He estimates that in the United States, 9.8 percent of men and 5 percent of women report same-gender sexual behavior since puberty; 7.7 percent of men and 7.5 percent of women report same-gender desire; and 2.8 percent of men and 1.4 percent of women report a homosexual or bisexual identity.

The data on the number of transgender people are even more limited. Some psychiatric literature estimates that 1 percent of the population may have had a transgender experience, but this estimate is based only on transgender people who might have sought mental health services (Seil, 1996).

Homophobia and Heterosexism

Having a general understanding of heterosexism, homophobia, and antigay bias is important for substance abuse treatment providers working with LGBT individuals. Alport (1952) defined prejudice as a negative attitude based on error and overgeneralization and identified the three interdependent states of acting out prejudice as verbal attacks, discrimination, and violence. Verbal attacks can range from denigratory language to pseudoscientific theories and findings, which serve as a foundation for discrimination and violence. Following this theory, prejudice and discrimination against LGBT individuals is formed, in part, by misinformation such as the following:

- All gay men are effeminate, and all lesbians are masculine.
- LGBT persons are child molesters.
- LGBT individuals are unsuitable for professional responsibilities and positions.
- LGBT persons cannot have fulfilling relationships.
- LGBT persons are mentally ill.

Once negative generalizations are formed about a group of people, some members of the majority group feel that they can treat the

other group differently. As the acceptance of negative stereotypes spreads, discrimination and violence can result.

Heterosexism and homophobia are used to describe the prejudice against LGBT people. **Heterosexism** is a prejudice similar to racism and sexism. It denies, ignores, denigrates, or stigmatizes any nonheterosexual form of emotional and affectional expression, sexual activity, behavior, relationship, or socially identified community. Heterosexism exists in everyone—LGBT individuals as well as heterosexuals—because almost everyone is brought up in a predominately heterosexual society that has little or no positive recognition of homosexuality or bisexuality. Heterosexism supports the mistaken belief that gay men—because they are attracted to men—are in some way like women, and lesbians, in turn, are in some way like men.

Homophobia, although a popular term, lacks precise meaning. Coined in 1972 to describe fear and loathing of gay men and lesbians, it also has been used by gay men, lesbians, and bisexuals to describe self-loathing, fear, or resistance to accepting and expressing sexual orientation (Weinberg, 1983). **Antigay bias** is another phrase to describe the first concept, and **internalized homophobia** is another phrase for the latter. Internalized homophobia is a key concept in understanding issues facing gay men, lesbians, and bisexuals in substance abuse treatment.

Examples of heterosexism in the United States include the following:

- The widespread lack of legal protection for individuals in employment and housing
- The continuing ban on lesbian and gay military personnel
- The hostility and lack of support for lesbian and gay committed relationships (except in Vermont) as seen in the passage of Federal and State laws against same-gender marriages
- The enforcement of outdated sodomy laws that are applied to LGBT individuals but not applied to heterosexual individuals.

Examples of heterosexism in the substance abuse treatment setting are as follows:

- Gay-bashing conversations
- Cynical remarks and jokes regarding gay sexual behaviors
- Jokes about openly LGBT staff members
- Lack of openly LGBT personnel
- Lack of inclusion of LGBT individuals' family members or significant others in treatment processes.

Substance abuse treatment providers should remember that LGBT clients do not know the reaction they will receive when mentioning their sexual orientation. For example, public opinion measures indicate that homosexuality is not widely accepted. In 1996, Gallup Poll data showed 50 percent of respondents reported that homosexuality was unacceptable and only 45 percent found homosexuality an acceptable lifestyle. In addition, Herek (1989) found that as many as 92 percent of lesbians and gay men reported that they have been the target of threats, and as many as 24 percent reported physical attacks because of their sexual orientation.

It is likely that all substance abuse treatment programs have LGBT clients, but staff members may not be aware that they are treating LGBT clients. Most treatment programs do not ask about sexual orientation, and many LGBT people are afraid to speak openly about their sexual orientation or identity. Treatment

programs also may not realize that they have LGBT staff members, who can be a great resource for treating LGBT clients.

How Heterosexism Contributes to Substance Abuse

When treating LGBT clients, it is helpful for providers to understand the effect of heterosexism on their LGBT clients. The role of heterosexism in the etiology of substance abuse is unclear. Heterosexism instills shame in LGBT individuals, causing them to internalize the homophobia that is directed toward them by society (Neisen, 1990, 1993). Some LGBT individuals may use intoxicants to cope with shame and other negative feelings. Some LGBT individuals learn to devalue themselves and value only heterosexual persons instead. The negative effects of heterosexism include the following:

- Self-blame for the victimization one has suffered
- A negative self-concept as a result of negative messages about homosexuality
- Anger directed inward resulting in destructive patterns such as substance abuse
- A victim mentality or feelings of inadequacy, hopelessness, and despair that interfere with leading a fulfilling life
- Self-victimization that may hinder emotional growth and development.

Recognizing that heterosexism is a type of victimization helps the counselor and client draw a parallel with recovery from other types of victimization, whether they are culturally or individually based. It is crucial that counselors and clients recognize that these effects result from prejudice and discrimination and are not a consequence of one's sexuality. It is not surprising to find that many LGBT individuals in therapy report feeling isolated, fearful, depressed, anxious, and angry and have difficulty trusting others. Meyer (1993) reports that the victimization of gay males in our society results in mental health consequences for individuals. A skilled substance abuse treatment counselor should be attentive to the negative effects that prejudice produces when working with LGBT clients.

Perspectives on Homosexuality

Homosexuality, as a specific category, was not described in the medical or psychiatric literature until the early 1870s. The fledgling psychoanalytic movement regarded homosexuality as a topic of special interest. Sigmund Freud believed a person's sexual orientation, in and of itself, did not impair his or her judgment or cause problems, and Freud set a positive tone when he supported homosexual colleagues in medical and psychiatric societies. Even so, European psychoanalytic organizations did not welcome gay men and lesbians as members in the early years of psychiatry, and many American psychiatrists and psychoanalysts promoted the attitude that homosexuality was a mental disorder.

Bieber and colleagues (1962) proposed that childhood influences and family upbringing were responsible for producing male homosexuality and described the classic combination of a distant, uninvolved father and an overinvolved mother. They did not consider biology or genetics as playing a role. Other psychoanalytic writing also refuted a biological component to female homosexuality, seeing it as caused primarily by early developmental disturbances.

Alfred Kinsey introduced new perspectives on homosexuality with his studies of sexual behavior (Kinsey, Pomeron & Martin, 1948; Kinsey et al., 1953). Although his studies have been criticized for a variety of reasons, such as poor sampling methods, the studies greatly

increased Americans' awareness of sexuality and the range of sexual behavior.

The psychologist Evelyn Hooker (1957) demonstrated that no discernible differences existed between the psychological profiles of gay men and those of heterosexual men, effectively beginning the debunking of the theory that homosexuality is a mental illness. Psychiatrist Judd Marmor (1980) recognized that homosexuality could not be explained in a single dimension and helped support exploring the biological, genetic, psychological, familial, and social factors involved in the formation and expression of a homosexual orientation.

In 1973, the American Psychiatric Association, after extensive scientific review and debate, stopped classifying homosexuality as a mental illness. Homosexuality is now seen as a normal variation of human sexual and emotional expression, allowing, it is hoped, a nonpathological and nonprejudicial view of homosexuality as well as of LGBT people. LGBT people and homosexual and bisexual behavior are found in almost all societies and cultures in the world and throughout history (Herdt, 1996). But the degree of tolerance and acceptance of them has varied considerably in different periods of history and from country to country, culture to culture, and community to community. Anthropological studies that have observed homosexual behavior in other cultures may help put homosexuality in global perspective and may contribute to understanding some of the issues facing American LGBT individuals who are from ethnic or cultural minority groups, such as African Americans (Jones & Hill, 1996), Asian Americans (Nakajima, Chan & Lee, 1996), Latinos/Latinas/Hispanics (Gonzalez & Espin, 1996), and Native Americans (Tafoya, 1996).

The genetic and biological contributions to sexual orientation have been studied increasingly in recent years. Unfortunately, the biological studies often grow out of the confusion between sexual orientation and gender identity. Many studies have tried to demonstrate that physical traits in gay men resemble those of women or have tried to identify traits in lesbians that resemble those of males. These views are based on the belief that, if a man wishes to be with a man, he must somehow be like a woman, and a woman wishing to be with a woman must, in some way, be like a man.

The Kinsey Institute has supported surveys and studies of both sexual behavior and sexual orientation and concluded that homosexuality must be innate, that is, inborn, and is not influenced developmentally by family upbringing (Bell & Weinberg, 1978; Bell, Weinberg & Hammersmith, 1981; Weinberg & Williams, 1974). The studies noted the diversity and variety of gay men and lesbians, recognizing that there was no uniform way to be or become gay or lesbian in our society.

Lesbianism and female homosexuality have also been studied from a nonpathological perspective. Magee and Miller (1998) reviewed these efforts and found no psychodynamic etiologies to female homosexuality and that each lesbian is unique and without stereotypic characteristics.

Studies of intersexual people, that is, people with sexually ambiguous genitalia or true hermaphrodites, are often analyzed. Hermaphrodites have both male and female reproductive organs. These studies ultimately are about gender role expectations and do not contribute to our understanding of homosexuality.

The most promising areas of study involve genetics and familial patterns. Although the gene has not been identified, Hamer and Copeland (1994) have reported a linkage on the X chromosome that may influence homosexual orientation. The genetic and familial patterns studied by Pillard, Bailey, and Weinrich and their colleagues (Bailey et

al., 1993; Bailey & Pillard, 1991; Pillard, 1996) have demonstrated the most consistent and verifiable data. Pillard found that gay men are much more likely to have gay or bisexual male siblings than heterosexual males—based on the incidence of homosexuality—but are not more likely to have lesbian sisters than are heterosexual males. Lesbians are more likely to have lesbian sisters but are not more likely to have gay brothers.

Combined with other twin and heritability studies, this research helps explain the probable genetic substrate of sexual orientation, with different genetic influences for male homosexuality, male heterosexuality, female homosexuality, female heterosexuality, and, possibly, bisexuality. Although the complex set of behaviors and feelings of homosexuality could not be explained by a single factor, a genetic basis seems to be the foundation on which other complex biological, familial, and societal influences work to shape the development and expression of sexual orientation (LeVay, 1996).

Perspectives on Bisexuality

Bisexuality has also existed throughout recorded history. Freud believed in innate bisexuality and that an individual evolves into a heterosexual or a homosexual, rarely a bisexual (Freud, 1963). Many bisexuals still find themselves contending with this lack of acknowledgment that a bisexual orientation can be an endpoint in itself and not just a step toward heterosexuality or homosexuality.

It is helpful for providers to know that the clinical issues facing bisexuals often are problems resulting from the difficulty of acknowledging and acting on a sexual orientation that is not accepted by the heterosexual majority but also not accepted by many gay men and lesbians.

Some people of color in the United States or people from different cultures may define themselves as bisexual, even if they focus exclusively on people of the same sex (Gonzalez & Espin, 1996). This perspective may be their way of coping with the stigma of homosexuality. Reviews that discuss theory and clinical issues include those by Weinberg, Williams, and Pryor (1994); Klein and Wolfe (1985); and Fox (1996).

Sexual Orientation Over Time

Although this chapter presents sexual orientation as belonging to one of three categories—homosexual, bisexual, or heterosexual—clearly sexual feelings, sexual behaviors, and sexual orientation may vary over time. As Kinsey found, sexual behavior ranges over a continuum from sexual activity with people of the same sex exclusively to sexual activity with people of the opposite sex exclusively, and most people's behavior falls somewhere in between. Sexual orientation also follows the same continuum—from sexual interest in people of the same sex exclusively to sexual interest in people of the opposite sex exclusively.

The mapping of sexual orientation over time has not been well studied. It seems that most people have a fairly stable and fixed sexual orientation, once they become aware of their sexual orientation. Nevertheless, some people's sexual orientation may vary. Women's orientation may be more changeable than men's, possibly because of society's homophobia and because men are more uncomfortable with a nonheterosexual identity. Some people may not become fully aware of their orientation for years and may seem to change sexual orientation when, in fact, they are just becoming conscious of their true orientation. This knowledge may help providers support their LGBT client whose confusion about sexual issues is interfering with recovery from substance abuse.

Some types of therapies claim to be able to change a person's sexual orientation. These conversion therapies or reparative therapies are often practiced by religiously based therapists or by some psychoanalysts who still consider homosexuality a mental illness. These therapies treat people who are uncomfortable with being gay, lesbian, or bisexual and—rather than helping an individual become comfortable with his or her inborn and natural sexual orientation—make the individuals even more uncomfortable and ashamed about being different. These attempts to change orientation may result in a temporary change of behavior. A gay man may stop having sex with other men or have sex with women, but his actual sexual orientation, expressed in his sexual fantasies, desires, or thoughts, possibly will not change. Almost all major mental health and medical organizations have condemned these therapies as ineffective and potentially harmful because they make the person feel guilty and ashamed (Haldeman, 1994).

Assessing Sexual Orientation

If a substance abuse treatment provider is concerned that a client is confused about his or her sexual orientation, some evaluation tools are available to help assess a client's feelings. Coleman (1987) devised a relatively simple assessment tool to help map out or identify the sexual orientation of clients (see exhibit 1–1). The questionnaire considers the combination of sexual behavior, fantasies, feelings, and self-identification that contributes to sexual orientation. This tool may be a useful way to introduce a discussion about sexual orientation with clients who are uncomfortable with the topic. It may also help people understand the complexity of sexual expression and their comfort level with it. However, providers should be sensitive to the individual situation of the client in both administering and interpreting the instrument.

Life Cycle Issues

LGBT individuals face many of the same issues all people face as they progress through life. However, LGBT youth may have an especially difficult time. During adolescence, teens are under pressure to conform, and extraordinary effort and courage may be required for an LGBT teenager to "come out" to peers and family. Gay and lesbian youth may be subject to sexual abuse or exploitation sometimes related to their insecurity and low self-esteem. LGBT youth may face significant stress in coping with the attitudes of peers, teachers, and parents.

Older adolescent and young adult LGBT people focus on identity development through school, career choices, and sexual exploration and relations. Their social life often revolves around bars or other settings that promote drug and alcohol use (D'Augelli, 1996). When LGBT adolescents come out to their family, the result can range from understanding and support to verbal and physical abuse. Some youth run away from home and live on the streets (Savin-Williams, 1994).

Many LGBT people consider becoming part of a couple an important part of life. Although there are no legal sanctions for such relationships, except in Vermont, the majority of gay people are in relationships, and many are as committed as traditional heterosexual couples (Klinger & Cabaj, 1993). Some LGBT people are parents; they have had or adopted children (Patterson, 1995). LGBT clients belong to a family of origin. Depending on the circumstances, the relationship may be healthy or strained. Some LGBT people create their own family of choice consisting of a close network of friends that serves the needs often met by traditional families. Treatment providers need to consider an LGBT client's partner, children, family of origin, and family of choice when providing care.

Older LGBT individuals may experience a sense of loss related to the aging process and associated changes in their physical attractiveness and capacities. This state may be further compounded by the lack of a partner or a legally sanctioned relationship. Consequently, their sense of a purpose and a future may become hazy and may be expressed in emotional and substance abuse problems (Kertzner & Sved, 1996).

Older LGBT people face the same concerns as other older persons regarding living arrangements and loss of loved ones and social supports. These concerns may be exacerbated for some LGBT people by HIV-related losses and limited familial support, that is, not having children and being isolated from their family of origin. Some people in this age group may need treatment for substance abuse or emotional issues avoided or ignored over the years (Berger & Kelly, 1996).

Summary

It is hoped that the information in this chapter helps providers improve their ability to provide competent and effective treatment. Treatment can be enhanced by a substance abuse treatment provider who is knowledgeable about the unique needs of LGBT clients. A provider who understands and is sensitive to the issues surrounding sexual and gender identity, homophobia, and heterosexism can help LGBT clients feel comfortable and safe while they confront their substance abuse and start their journey of recovery.

Chapter 2 Cultural Issues in Working With LGBT Individuals

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What providers will learn from this chapter:

- What cultural competence is
- How cross-cultural issues affect substance abuse treatment
- What the dimensions of culture are
- Treatment issues that are unique to different ethnic groups
- Perspectives on gay culture

Introduction

This chapter presents information to help providers understand cultural issues relevant to treating lesbian, gay, bisexual, and transgender (LGBT) clients. To provide culturally competent treatment, providers must possess attitudes that reflect openness to other cultures, values, and beliefs; a willingness to assess and change their own beliefs; and the ability to appreciate diversity. Providers need to know about the social and cultural context in which their clients live and abuse substances and be receptive to information that may differ from their personally held views (CSAT [Center for Substance Abuse Treatment], 1998a).

Providers can play an important role in the healing process of LGBT individuals by being aware of the community, traditions, and heritage of their LGBT clients. The information that follows includes broad generalities intended as starting points for providers in their work with individual clients. It is not intended as a thorough discussion of the topic.

Definitions of Terms

Culture refers to the customary beliefs, social norms, and material traits of a racial, religious, or social group. It affects the group

members' viewpoints: how they act; how they think; and how they see themselves in relation to the rest of the world. Culture is transmitted through language, symbols, and rituals.

Ethnicity describes a population or group having a common cultural heritage that is distinguished by customs, characteristics, language, and common history.

Diversity refers to differences in geographic location (rural, urban), sexual orientation, age, religion or spiritual practice, socioeconomic status, and physical and mental capacity.

Important reference materials on cultural competency include the following:

- CSAT's publication *Cultural Issues in Substance Abuse Treatment*, 1999b
- CSAT's Technical Assistance Publication (TAP) 21 *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, 1998b.

Cultural Competency Overview

Cultural competency is a set of academic and interpersonal skills that assists individuals in increasing their understanding and appreciation of cultural differences and similarities within, among, and between groups (Woll, 1996). It requires a willingness and an ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports. A culturally competent program is defined by CSAT (1994a) as one that demonstrates sensitivity and understanding of cultural differences in treatment and program design, implementation, and evaluation. Within the treatment setting, cultural competency is a fundamental component that helps individuals develop trust as well as an understanding of the way members of different cultural groups define health, illness, and health care (Gordon, 1994).

Substance abuse treatment providers may use their understanding of the client and the client's cultural context to develop a culturally appropriate assessment, identify problems, and choose appropriate treatment strategies for the client. A culturally competent model of treatment acknowledges the client's cultural strengths, values, and experiences while encouraging behavioral and attitudinal change. Treatment services that are culturally responsive are characterized by the following:

- Staff knowledge of the client's first language
- Staff sensitivity to the cultural nuances of the client population
- Staff backgrounds representative of those of the client population
- Treatment modalities that reflect the cultural values and treatment needs of the client population
- Representation of the client population in decisionmaking and policy implementation.

These aspects alone do not constitute cultural competency, nor do they automatically create a culturally competent system. Culturally competent systems include both professional behavioral norms for treatment staff and the organizational norms that are built into the organization's mission, structure, management, personnel, program design, and treatment protocols. In other words, culturally competent systems need to implement cultural competency in attitudes, practices, policies, and structures (Mason, 1995).

Interpreting behavior without considering its cultural context can lead to poor, sometimes detrimental, treatment outcomes. The covert prejudice of the treatment staff and language

and cultural differences undermine efforts to help clients recover from substance abuse (CSAT, 1999b). However, if practitioners are to move from accommodation to inclusion in their helping practices, they must alter practices to meet the needs of their clients.

Assimilation and Acculturation

Assimilation and acculturation are key concepts in cultural competency. The extent of a person's assimilation or acculturation influences individual behavior and may affect the treatment outcome. When working with LGBT people from minority populations, providers must assess their level of acculturation and assimilation.

- **Assimilation** is adaptation to a new culture by taking on a new identity and abandoning the old cultural identity.

- **Acculturation** refers to accommodation to the rules and expectations of the majority culture without entirely giving up cultural identity.

The four interpersonal styles represented below may be exhibited by clients in treatment and should be assessed by counselors during substance abuse treatment (Bell, 1981). These styles are fluid, meaning individuals can move among them depending on the context or stage of their development or both.

Assimilated individuals consciously or subconsciously reject their culture of origin in favor of their adopted culture. These clients may resist placement in a group with clients of their own ethnicity or may prefer a clinician from their adopted culture.

Bicultural, or multicultural, individuals are proud of their cultures and can function in, fulfill their needs through, and be proud of the dominant culture. Their emotional, educational, economic, and spiritual needs are usually fulfilled in a diverse, integrated living environment that honors two (or more) cultures. A bicultural or multicultural client is likely to be comfortable in any clinical setting with relative ease. However, one of the difficulties of this interpersonal style is cultural or racial schizophrenia (Bell, 1981): the feeling of not belonging to either community. These clients face special challenges that may need to be addressed in treatment.

Culturally immersed individuals have rejected mainstream culture, and their emotional and spiritual needs are met exclusively in their ethnic community or in the gay community. The effectiveness of their treatment may depend on the ability of the provider to be supportive as clients work through issues related to being a person from a minority group.

Traditional individuals are defined as carriers of the community ethos. They neither overtly accept nor reject their ethnic identity. Traditional persons have most of their emotional, spiritual, and, to some degree, educational needs met through their ethnic community and have limited contact with the dominant culture or any outside communities. Their economic needs are met primarily in the context of the majority culture and sometimes involve power imbalances that increase their distrust of other groups. For traditional individuals, entering into a mainstream treatment program is usually a frighteningly foreign experience that calls for sensitivity by treatment staff.

The heterogeneity of ethnic culture emphasizes the need for providers to appreciate clients' cultural context and individuality. This emphasis allows for more culturally appropriate interventions and focuses on the importance of matching client and provider according to interpersonal styles rather than ethnicity alone.

General Issues in Cross-Cultural Treatment

Our culture guides how we act and think as well as how we come to understand who we are and how we fit into the world. Cultural norms are rules of conduct that are internalized by the members of the group and embody the fundamental expectations of the group. Cultural rules resemble family rules—often the strongest are the ones not spoken. Because cultural rules are usually reinforced by parents or special people in one's life, the rules are hard to defy. In addition to cultural norms, five general aspects of culture need to be considered if cross-cultural treatment is to be effective. They are as follows:

Values of a culture play an important role in determining how one behaves. Cultural values vary among different groups. For example, some cultures admire assertive behavior, but some Asian cultures consider such behavior rude or disrespectful. In American Indian culture, silence is highly valued—a difficulty for counselors who are trained to assess commitment by verbal expression.

Language is the primary tool for our work. Certainly, a client whose native language is not spoken in treatment is at an extraordinary disadvantage. All languages are complex, and immigrants find adjusting to the nuances of a new language difficult. The meaning of many words or phrases varies depending on context, tone, audience, and intended message. For some clients, using bilingual services and staff greatly increases the effectiveness of treatment. However, translation into the client's primary language is not enough. Materials or oral translations need to be adapted to be culturally appropriate for the intended audience. Historical factors such as discrimination and how a person interprets another's actions also impact communication and need to be considered. Counselors should verify with the client that the message is understood as meant. This verification should be done in a sensitive manner that does not embarrass the client.

Nonverbal behavior is extraordinarily powerful. Interpretations of touches, gestures, and eye contacts are shaped by personal experience and culture. For instance, a person in a prison community does not use direct eye contact because it is a sign of disrespect in that circumstance. In the Latino culture, touching the person being addressed is a sign of attentiveness. It is important for counselors to be sensitive to a client's style of nonverbal communication and to consider the degree of familiarity and the context of the contact. Counselors should ask clients about any nonverbal behavior they do not understand. If counselors question clients in a nonthreatening way, the clients usually are willing to explain.

Learning styles vary among individuals and cultures. Typically, treatment programs use a Western learning style of formal, often written instruction. For example, many treatment centers require that clients read literature from Alcoholics Anonymous and write out the step work without assessing whether the clients understand the information. Nonliterate clients or those with low reading comprehension would be better served if culturally appropriate audiotapes or videotapes also were used. Clients from a cultural group with a tradition of storytelling also may welcome alternative forms of communication and the use of a variety of methods to transmit information.

Healing is the essential task of treatment. With all clients, counselors need to create an environment where clients can heal. It is critical for counselors to assess each client's sources of comfort, to understand the individual's beliefs and customs around healing—what will make the client feel better—and to understand the person's definitions of illness and health.

The Western health care tradition tends to compartmentalize health issues and assumes

that healing should be left to those who know best—medical personnel. However, this assumption is being challenged by some people and health care providers who are seeking alternative treatment methods such as folk medicines, acupuncture, herbs, and massage. Some health care providers and patients are also forming new treatment partnerships instead of the authoritarian model of physician-patient. Substance abuse counselors need to determine what the client believes will make him or her healthy and what needs to be included in the treatment plan. This determination is particularly important because what a person believes will make him or her healthy has a great impact on the recovery process. Clients' resistance to a particular treatment method can sometimes be traced to their healing belief system.

Dimensions of Culture

Many people experience some form of discrimination, prejudgment, bias, closemindedness, or other exclusionary attitudes because of their race, ethnic origin, gender, sexual orientation, religion, or class. Discrimination toward minority groups can come from those of the majority culture; toward other minority groups or the majority culture, from a minority person or group; or toward an LGBT individual, from someone in the majority culture, other ethnic groups, and the individual's own ethnic group.

Little research has been done on the interactions among ethnic diversity, homosexuality, and substance abuse. Providers need to remember that LGBT clients from ethnic minority groups may have additional problems that will affect their recovery from substance abuse. LGBT members of an ethnic minority group need to learn the norms of the mainstream culture, their own minority culture, and gay culture—norms that may conflict. Juggling the demands of these norms may be confusing and problematic, and the substance abuse treatment provider may need to help the client negotiate the confusing and contradicting norms while the client is in treatment. An LGBT individual may have a stronger connection to his or her ethnic group than to the LGBT community, or the dominant allegiance may be to the LGBT community. It is important that providers invite clients to explain their cultural context and how they feel about their place in society, assess with clients their placement on the continuum from assimilated to traditional, and explore the meaning of these variables in their clients' recovery. It is of utmost importance for counselors to be aware of how their own cultural values, biases, and attitudes influence their practice and how they affect their behavior toward coworkers and clients.

Introduction to the LGBT Community and Culture

Substance abuse treatment providers need to be aware that LGBT persons do not fit the prevalent stereotype of well-dressed, middle-class urban dwellers; drag queens; or masculinely dressed females. LGBT people live and work in all segments of society. They are from every minority, cultural, racial, and ethnic group. They are members of every nationality, religion, and age group and are from every educational and socioeconomic level. Although some urban centers have populations that are more accepting of LGBT lifestyles than others, and thus are magnets for LGBT persons, LGBT people live in rural, urban, and suburban areas and in every State. LGBT clients can ask for substance abuse treatment services anywhere in the country and not only in large urban areas.

The LGBT minority group differs from other minority groups in that LGBT persons do not come from a common geographic area or have certain physical characteristics in common.

Gay Culture

There is a lively debate in the LGBT community over what constitutes gay culture. Is it several cultures within one culture? Do lesbian, gay, bisexual, and transgender people each have their own cultures? Gay culture is as diverse as all its members. However, there is no question that many LGBT individuals experience a way of life that is considered a culture. Although lesbian, gay, bisexual, and transgender individuals from different backgrounds experience their communities differently, they share the belief in the legitimacy of their way of life. Substance abuse treatment providers should understand that the gay community possesses common knowledge, attitudes, and behavioral patterns and has its own legacy, argot, folklore, heritage, and history.

Gay culture is different in the degree to which it is submerged within other cultures and in the way that these cultures tend to affect it. LGBT people's behavior is still stigmatized, and because there is usually no way of identifying LGBT people apart from their own disclosure or identification with gay culture, gay culture is essentially hidden in the larger community.

In contrast to how members of ethnic cultures are marginalized, LGBT individuals may receive disapproval and censure from those whom they most trust and rely on—parents, relatives, religious leaders, teachers, and friends. Most members of ethnic minorities can escape discrimination by returning to a supportive family or neighborhood. This is not always true for LGBT persons. When they are growing up, their positive role models are not easy to identify. This isolation sets LGBT minority members apart from ethnic minority group members who are usually in close proximity to other members. The LGBT culture is one that is not developed, taught, or transmitted by families.

Although homosexuality has existed throughout the ages and in many different cultures, gay culture as it is known today began to emerge in 1969, when the New York City police raided a popular gay bar, the Stonewall Inn. At the time, raids of gay bars were conducted regularly with little resistance. However, that night the event erupted into a violent protest as the crowd fought back. The protests that followed, known as the Stonewall Riots, gave birth to the gay rights movement. Before Stonewall, public expression of LGBT life and experience was rare.

The gay rights movement spawned calls for gay pride and civil rights. Since Stonewall, some aspects of gay culture have blossomed. Gay media, books, magazines, movies, newspapers, and Internet sites abound. Attention is lavished on gay heroes—public figures who are "out" and who work to improve the lives of LGBT individuals. Many large companies market their products or services to the lesbian and gay community. Several LGBT organizations exist, and many companies have LGBT employee organizations.

Part of gay culture is a celebration of being gay. Gay pride celebrations are held in June to mark the anniversary of the Stonewall Riots. At gay pride celebrations, the invisible LGBT minority makes itself visible and celebrates its uniqueness, the struggle for civil rights, the cultural gains, and its heroes. The event usually consists of a parade, musical entertainment, and art events showcasing LGBT authors and performing artists and is attended by representatives of LGBT social and service organizations. Gay pride celebrations provide an opportunity for substance abuse treatment providers to reach out to the LGBT community.

An aspect of the debate within the gay community about gay culture involves gay rights. Because public acceptance is important, many LGBT persons want to advance the message that LGBT individuals are no

different from non-LGBT persons. Some LGBT persons worry that highlighting the similarities and the positive aspects of gay culture will mean the loss of that culture as the LGBT community is accepted into mainstream culture. Some believe that the gay community should try to transform mainstream society rather than join it. Another aspect of the debate involves some LGBT individuals who believe there is only one way to be gay and do not honor LGBT persons with other lifestyles or opposing views. Bisexuals have complained that lesbians and gay men do not accept bisexuality as a legitimate sexual orientation but regard it as a developmental phase on the way to acceptance of lesbianism or homosexuality exclusively. Substance abuse treatment providers should keep in mind that this disagreement may be very confusing to clients who are questioning their sexual orientation or to self-identified LGBT clients who may feel unaccepted by the LGBT community because they have a different lifestyle.

Values. Compassion and authenticity are important ideals for LGBT individuals. The abilities to invent their own relationships, cultivate the arts, build a community, and create a culture are sources of pride in the LGBT community.

Language. Some LGBT individuals disapprove of the words used to describe them, and the reasons can be helpful in understanding LGBT clients. For some LGBT people, the term "homosexual" overemphasizes sexuality and seems to indicate that the sex act is more important to homosexuals than it is to heterosexuals. It also resurrects memories of when homosexuality was considered a psychiatric disorder. Hence, the words "homo," "bi," "queer," or "gay" are preferred by some LGBT persons. However, some LGBT persons are offended by the term "queer." Some lesbians may prefer to be called dyke or gay, instead of lesbian. Transgender persons may prefer the less clinical term "trans." It is important to call a transgender client by his or her preferred name and always to use the gender designation that the client has chosen. Given these conflicting opinions, providers should ask a self-identified LGBT client what he or she prefers to be called. The choice is a conscious and sometimes rather emotional decision and should be honored. A provider's sensitive use of language can be an important sign of respect and can help create a healing environment for LGBT clients. When clients are confused and questioning their sexual orientation, the provider should be sensitive to the clients' confusion.

LGBT individuals have a creative vocabulary on the subject of sexual orientation because they may often use code words for safety reasons. For example, a gay man or lesbian uses the following to acknowledge someone with a same-sex preference: one of us, family, member of the church, cousin, colleague, or brother or sister. The vocabulary varies, and providers should listen carefully and ask questions about the meaning and use of unfamiliar terms.

Nonverbal behavior. LGBT individuals rely tremendously on nonverbal cues to establish whether the situation is safe for them to be themselves. As they walk into a treatment center, they will be looking for evidence that they are accepted and welcome. Do they see a rainbow-colored flag? A "Straight But Not Narrow" bumper sticker? Is there a mission statement that includes a commitment to honoring diversity or a commitment to treating LGBT clients? Do they see gay or lesbian staff members? Until the LGBT client feels a degree of safety, he or she will be guarded. A provider who is unaware of this may believe that he or she is seeing the client's real personality when, in fact, the client is on alert and hiding it from the provider. It is important for providers to signal respect, openmindedness, and acceptance by using appropriate gestures and vocabulary.

Learning styles. Much of what is taught by institutions and teachers does not reflect the personal experiences of many LGBT people. Experiential learning techniques such as role-plays may be more appropriate, and peers with similar experiences are likely to have influence. Any materials used in treatment that acknowledge the LGBT experience will be more effective than those that do not mention it.

Healing. LGBT individuals may distrust the medical establishment and may be somewhat more likely than the general population to rely on the personal experiences of those they trust or other LGBT persons to select providers and treatments.

Ethnic Minority Groups

The cultural norms and beliefs of an ethnic group can have a significant impact on an LGBT person's feelings about his or her sexual orientation or gender identity, his or her ability to express that identity, and how other members of the ethnic group treat the LGBT person. Although an LGBT orientation conflicts with mainstream cultural values, it may be just as, or even more, unacceptable in some ethnic minority groups. Many ethnic groups value strong family ties and traditional gender roles and expect that their children will carry on the family name and traditions through marriage and children. Some families see LGBT behavior as arising from a decadent Western society and as a rebellion against the family and traditional beliefs, instead of as a part of a person's identity. Consequently, LGBT behavior is difficult for family and friends to understand and tends to become invisible.

Some LGBT individuals of color may be accepted by their parents but feel alienated from their ethnic community. Some may distance themselves from their cultural communities and turn to the LGBT community for support and validation. Support groups for LGBT African Americans, Latinos, and Asian/Pacific Islanders are active in large cities, but many LGBT individuals of color find themselves in predominantly white, middle-class LGBT communities. It is assumed that the LGBT community with its experience of discrimination would be tolerant of diversity. However, ethnic minorities are discriminated against by some LGBT individuals. LGBT people of color may feel they have double minority status that may compound negative consequences such as a poor self-image, low self-esteem, inadequate coping mechanisms, and substance abuse. LGBT ethnic minorities face greater challenges than their counterparts in mainstream society, and it is important for substance abuse treatment providers to validate these experiences and challenges.

American Indian/Alaska Natives

The number of LGBT individuals in American Indian and Alaska Native communities is not definitely known, although it is believed to resemble the parameters of the dominant population. From self-reports and the small amount of research findings available, American Indians and Alaska Natives in gay or lesbian relationships report a higher degree of bisexuality than do their Caucasian counterparts.

Historically, some American Indian and Alaska Native communities viewed the role of a native person who was different from other community members as having a strong spiritual component. Being different was seen as a result of a spiritual experience and a path chosen by the Creator or the Spirits for that person. Many American Indian and Alaska Native communities used the term "two-spirited" to describe LGBT individuals. Traditionally, American Indian and Alaska Native nations were taught to celebrate the differences and to see all their members as sacred beings fashioned by the Creator. At least 168 of the more than 200 Native American languages still spoken today have terms for genders in addition to male and

female. Many LGBT people prefer the term "two-spirited" because it expresses their sense of combining a male and female spirit. It is also considered empowering for a person to choose what to be called as opposed to accepting a label given by another. This may be particularly true for this group. In the past, the culture, language, and religion of American Indian and Alaska Native people were oppressed by the majority culture. Christian missionaries used their influence in converting many traditional rituals into Christian rituals. Many native children were sent to government-run boarding schools and were prohibited from speaking their native languages and practicing their native customs. Along with erasing traditional roles, the traditional respect for two-spirited people also was diminished.

While American Indian and Alaska Native clients are in treatment, it is important to determine their level of acculturation, their tribal affiliation, and the degree to which their sexual or gender identity is accepted by their tribal community and family. In many communities, being accepted by one's family is a measure of health and connectedness. If the family has difficulty accepting the client's sexual orientation, recovery from substance abuse may be hindered. Reintegrating the individual into his or her family may help in the recovery process. Becoming reconnected with family is seen as necessary for health in native tradition. Achieving awareness of one's sexual orientation or identity may occur in a different way for native men and women than for their non-Indian LGBT counterparts.

Values. Some common tribal values are the importance of sharing and generosity, allegiance to one's family and community, respect for elders, noninterference, orientation to the present time, and harmony with nature. Respect for individual autonomy within the community, respect for family, and honoring the earth are entwined, and each person depends on others for meaning and existence. Traditional beliefs support the existence of a Supreme Creator and the view that each human has many dimensions such as the body, mind, and spirit. Like humans, plants and animals are part of the spirit world that coexists and intermingles with the physical world.

Language. Words are to be honored and not wasted. Language is used to impart knowledge, often through stories. The legends and stories often have specific meanings and involve intricate relationships. Use of symbolism, animism, subtle humor, and metaphors is important. Direct questioning is not as important. Practitioners need to be aware of both their language and nonverbal behavior when communicating with this group.

Nonverbal behavior. Their emphasis on observant, reflective, and integrative skills leads American Indian and Alaska Natives to behavior patterns of silence, listening, nonverbal cues, and learning by example. Some traditional natives would view a firm handshake as intrusive and rude; eye contact is used minimally; and a passive demeanor is appropriate.

Learning styles. Historically, their survival depended on learning the signs of nature, so observation is central to American Indians and Alaska Natives. Learning is accomplished by watching and listening and through trial and error. Cultural norms and values are passed from generation to generation through rituals, ceremonies, and the oral tradition of storytelling. The relationship with a teacher is important, but trust needs to be established.

Healing. Wellness is harmony of the mind, body, and spirit, and native people feel they are responsible for their own wellness. Healing is interconnected with the whole person and rooted in spiritual beliefs connected to the earth and nature. Some traditional practices are the talking circle, sweat lodge, four circles, vision quest, and sun dance and involve community

healers, elders, and holy persons (CSAT, 1999b).

African Americans

Homophobia in the African-American community is often more intense than in the dominant community. In the past, the sexual orientation of African-American lesbians and gay men was often known by the community although it was not discussed. Many African-American individuals, particularly men, call themselves bisexual instead of gay. Many African-American LGBT individuals operate in separate spheres and may perform community service in the African-American community, but they primarily socialize within the African-American LGBT community. Identifying oneself as an LGBT individual publicly may put an African American at risk for losing his or her most important support system—the African-American community.

Many LGBT African Americans say that they do not feel welcome or comfortable in predominantly Caucasian LGBT settings (e.g., clubs, bars, pride events), and racist incidents have been reported. Diversity in the LGBT service provider community is essential to accommodate for the distrust between African Americans and Caucasians. Many service provider agencies targeting African Americans were formed during the height of the HIV/AIDS epidemic.

Focus groups consisting of African-American gay men and lesbians conducted in California by Michael Browning of Day One in Pasadena, a member of this publication's Steering Committee, clearly stated that they did not want to be called queer and considered it a negative term. Substance abuse treatment counselors need to refrain from using the term, especially if they are working with African Americans.

Focus group members stated that religion remains important to many gays and lesbians in African-American communities, even though some have had negative experiences with organized religious groups. Many treatment programs have some religious context (whether spoken about or not), and focus group members felt that including spiritual activities, music, and practices that are more indigenous to African-American communities would be helpful in treatment.

Values. Interpersonal relationships are highly valued, and the identity of African Americans is tied to their group identity. The self is considered an extended self, and this group orientation contrasts with the wider cultural norm of individualism. The community, social organizations, neighborhoods, and kinship relationships provide aid and support. African-American families vary from nuclear to extended. Female-headed households predominate in some socioeconomic levels, but marriage is still highly valued. Rearing children is considered a communal responsibility.

Language. Language is passionate and full of action. Dialects and slang are used in some geographic locations and need to be understood by providers. "Same-gender-loving" is a term used by many African-American LGBT individuals. The appropriate form of address is by title (e.g., Ms., Dr., Rev., Mrs.) rather than first name, unless permission is given to use the more informal address.

Nonverbal behavior. Body language is expressive and used extensively to help communicate. Movement, thought, and nonverbal behavior are spontaneous, and many African Americans are highly aware of nonverbal cues. Touch is important; however, observing personal space is one key to whether a person feels respected, and providers need to follow the client's lead.

Learning styles. Learning styles tend to be relational rather than analytical. Oral communication predominates in knowledge transmission. Tradition is highly valued over the visual and the written word. Teachers and students need to develop a trusting relationship. Storytelling is used to teach about life and pass on cultural values. The use of storytelling and African proverbs can enhance insights into treatment.

Healing. Healing occurs through laying on of hands, prayer, herbs, and the like. One is sick when one cannot do for oneself any longer, and recovery from illness usually is seen as possible with the help of God. For many, God and the spiritual community are based in the Christian church and organized religion.

Asian/Pacific Islanders

Asian/Pacific Islanders consist of more than 60 culturally distinct groups, practice several types of religion, and speak more than 100 languages and dialects. Their degree of acculturation and assimilation varies. The Asian/Pacific Islander cultures have few characteristics in common. For some Asian/Pacific Islander groups, "the traditional Asian/Pacific Islander approach to health and illness centers around balance and harmony. The ultimate goal is to attain a perfect balance among systems of the individual, society, and the universe at large" (Wong et al., 1998). Cohesiveness of the group is an important value, and because of this, shame is a frequently used social constraint to control or deter expressions of homosexual behavior (Wong et al., 1998).

Some Asian/Pacific Islander cultures believe that if one is vigilant in maintaining balance in one's relationships, then one cannot become ill. It is only when one is out of balance that disease occurs. In addition, prevention as conceptualized by most Asian/Pacific Islanders dictates that, as long as primary prevention behaviors are practiced, there is no reason for secondary prevention efforts, such as making regular visits to a physician (Wong et al., 1998). Providers need to understand this cultural value and adapt their prevention and treatment efforts accordingly.

Values. This culture is heavily based on interdependence, and family is central. The individual is expected to subsume his or her needs to those of the larger group—family, community, or other groups. Varying from one's prescribed role can cause shame and loss of face for the family. Authority and age are highly respected and honored; thus, there may be discomfort in addressing providers, particularly older ones, by their first names.

Language. Some of the languages spoken by Asian/Pacific Islanders do not have words for lesbian, gay, bisexual, or transgender. Without descriptive words, the formation of an LGBT identity may be precluded and an ambiguous social role for LGBT individuals may result. In other words, the behaviors may be practices that lack social legitimacy and may not be discussed. Thus, communication may be indirect, particularly about personal issues or sexual behavior. Initial communication during treatment may need to be indirect with a gradual increase in directness about the issue.

Nonverbal behavior. Nonverbal behaviors are as varied as the communities themselves. In some groups, bowing is important, as are related behaviors such as using both hands to present a business card to a colleague, the elderly, and people in authority. Same-sex touching (e.g., holding hands) is not uncommon in most Asian/Pacific Islander cultures; it is a gesture of affection, not sexual feeling.

Learning styles. Hierarchical societies support deference to authority (e.g., physicians, health care providers, teachers, the elderly). The learning style is likely to be traditional; information is disseminated or transmitted in one direction, from teacher to student.

Healing. Self-reflection through meditation is one traditional way to confront personal issues and increase self-knowledge. Ethics, as outlined by philosophers such as Lao Tzu and Confucius, provide standards for human behavior and regaining a healthy balance. Asian Americans who are Muslim, Christian, or Hindu may have very different beliefs. Eastern medicine is complex, and many recently arrived Asian Americans may still use traditional cures.

Hispanic Americans/Latinos

Hispanic Americans (also called Latinas and Latinos) are defined as individuals of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultures or origins, regardless of their race (CSAT, 1999b). LGBT Hispanics, regardless of the differences among the nationalities represented, have many common values, including strong religious faith, altruism, family values, and spirituality. They contribute greatly to their community, regardless of the fact that they may come from diverse and separate cultural systems and socioeconomic realities.

In treating Hispanic clients, the family is the cornerstone. The support network consists of the family and a host of other individuals who may or may not be related. For new immigrants, the stress of learning a new language, new cultural norms and behavior, and the sense of loss from leaving family and other loved ones behind can be overwhelming.

Homosexuality may be privately acknowledged, but it is usually not discussed openly. Hispanics may be more reluctant to self-identify as LGBT than members of the mainstream culture. The perception of sexuality as an indication of identity is often overridden by identification with the community. Mainstream culture tends to label a person who has a sexual encounter with someone of the same gender as gay, bisexual, or lesbian. In Hispanic culture, some men who have sex with men do not consider themselves gay if they play the dominant role in the sexual act. When treating Hispanic clients, providers should respect this distinction.

Values. Group needs and objectives, family values and ties, and trust (*confianza*) are respected. Traditional values, some of which are rooted in the Catholic faith, are honored. Many Hispanic Americans consider religion central to their lives. Latino/Latina clients appreciate recognition of the emotional, family, and spiritual challenges related to substance abuse problems. Clients likely will maintain a high level of privacy about subjects of a personal nature (illness, addiction, sexual behavior).

In most families, the family respects strong gender roles. Machismo, the strong sense of masculine pride or exaggerated masculinity, and other traditional male attitudes can be barriers to seeking treatment for substance abuse and to coming out. Males are the center of the family, and many gay, bisexual, and transgender men find it difficult to acknowledge their sexual and gender identities.

Drinking is a socially accepted behavior in some families, and young children are allowed to drink beer and tequila as a rite of passage. Caseres and Cortifias (1996) report that for gay Latinos "the bar can be a surrogate home where they can find their other family, who fulfill[s] some of their needs of emotional support in a nonjudgmental context . . . the bar life nurtures, relieves guilt, and becomes an emotional shelter where they can find a new, positive, and valuable world."

Language. Using nonscientific, nontechnical terms and descriptions applicable to the client's cultural background (Mexican, Colombian, Puerto Rican, etc.) is recommended. The use of Latino, Chicano, or Hispanic differs among groups and communities. An interpreter may

be necessary to successfully treat some Hispanic clients or their families, and bilingual staff members are an excellent resource.

Nonverbal behavior. A professional and respectful physical contact, such as shaking hands at every greeting, helps create a safe space for the client. Maintaining eye contact denotes attention and understanding.

Learning styles. Family members, especially heads of families, are a source of guidance, counseling, and instruction. It is important to empower individuals to learn about their situation and to know that they can seek support within their own community. It is necessary to remember that for most Hispanic Americans the learning process is based in the context rather than the process. Using a hypothetical third person when giving examples to avoid embarrassment and discomfort about intimate subjects is an effective approach.

Healing. Healing is influenced by strong religious beliefs that are often based on traditional Catholicism, although other practices may be followed. Spirituality and religious beliefs are generally very strong and can influence the decisionmaking or behavioral-change processes.

Summary

The information in this chapter is only a skeletal framework to introduce providers to the complex issues of cultural competency, ethnicity, and gay culture. Providers can help their LGBT clients by understanding their struggle and creating a safe and supportive treatment space. Cultural values and norms are powerful forces, and providers should be mindful that often it is hard for clients to abandon long-held cultural beliefs, even if they are harmful. The experience of expanding their knowledge of the cultural backgrounds of their clients can be rewarding and worthwhile for providers.

Chapter 3 Legal Issues for Programs Treating LGBT Clients

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What providers will learn from this chapter:

- How programs can protect the confidentiality of LGBT clients
- The legal barriers facing LGBT individuals
- The legal issues raised by HIV/AIDS
- What policies programs should adopt to ensure that clients and staff are fairly treated

Introduction

Lesbian, gay, bisexual, and transgender (LGBT) individuals with substance abuse problems are doubly stigmatized. As substance abusers, they are viewed by many as weak in character and moral fiber. As lesbian, gay, bisexual, and transgender individuals, they are reviled by some as deviant and immoral. They may encounter bigotry from employers, human service workers, criminal justice officials, the general public, and even their own families.

Two Federal (and a number of State) statutes protect recovering substance abusers from many forms of discrimination. However, in most areas of the country, LGBT individuals have no legal protection against discrimination in employment, housing, or access to social services. Protections fought for and won by women, racial minorities, and individuals with disabilities simply are not available for LGBT persons. Disclosure of sexual orientation can lead to an individual's being fired or being denied access to housing and social services—all with legal impunity. LGBT individuals may even lose custody of their children if their sexual orientation becomes known during a custody dispute.

Even in those States that have enacted statutes prohibiting discrimination on the basis of sexual orientation, LGBT individuals have sometimes been denied protection. Little wonder that LGBT individuals regard protecting information about their sexual orientation and substance abuse histories as

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critically important. Programs that treat this special population need to be particularly sensitive about maintaining clients' confidentiality, for the consequences of an inappropriate disclosure can be far reaching. (For a compendium of the law regarding discrimination against LGBT individuals, see www.lambdalegal.org.)

This chapter examines ways programs can safeguard information about clients' substance abuse histories, sexual orientation, and HIV status. It then describes how the lack of legal protection against discrimination can affect LGBT individuals in a variety of areas and how programs can help these clients protect themselves. Finally, the chapter outlines the laws protecting clients with histories of substance abuse and/or HIV/AIDS from discrimination.

Protecting the Confidentiality of LGBT Individuals in Substance Abuse Treatment Programs

Confidentiality Requirements

Concerned about the adverse effects stigma and discrimination have on clients in recovery and how stigma and discrimination might deter people from entering treatment, Congress passed legislation (42 U.S.C. §290dd-2) and the U.S. Department of Health and Human Services issued a set of regulations (Vol. 42 of the Code of Federal Regulations [CFR], Part 2) to protect information about clients' substance abuse treatment.

The Federal law and regulations severely restrict communications about identifiable clients by "programs" specializing, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for substance abuse problems (42 CFR §2.11). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid, such as tax-exempt status or State or local government funding coming (in whole or in part) from the Federal Government.

The regulations for communications are more restrictive in many instances than, for example, either doctor-patient or attorney-client privilege. They protect any information about an individual who has applied for or received any substance abuse-related assessment, treatment, or referral services from a program. They apply from the time the individual makes an appointment and apply to former clients as well. They apply to any information that would identify the individual either directly or by implication as a substance abuser. They apply whether or not the person seeking information already has that information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant. Violating the regulations is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (§2.4).

Programs can find detailed information about compliance with the regulations in Technical Assistance Publication 13 *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (CSAT [Center for Substance Abuse Treatment], 1999a), available from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Clearinghouse for Alcohol and Drug Information (NCADI) at 800–729–6686. What follows is a brief description of some of the regulations' major provisions.

When May Confidential Information Be Shared With Others?

The confidentiality regulations permit disclosure without the client's consent in several situations, including medical emergencies, reporting child abuse, and communications among program staff. (For a full discussion of these exceptions, see CSAT, 1999a.)

Consent: Rules About Obtaining Consent To Disclose Treatment Information

The most frequently used exception to the regulations' general rule prohibiting disclosure is client consent. (Parental consent must also be obtained in some States. See below.) The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Most disclosures are permissible if a client has signed a valid consent form that has not expired or been revoked (§2.31). To be valid, a consent form must be in writing and must contain **each** of the items specified in §2.31:

1. The name or general description of the program(s) making the disclosure
2. The name or title of the individual or organization that will receive the disclosure
3. The name of the client who is the subject of the disclosure
4. The purpose or need for the disclosure
5. How much and what kind of information will be disclosed
6. A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
7. The date, event, or condition upon which the consent will expire if not previously revoked
8. The signature of the client (and, in some States, his or her parent)
9. The date on which the consent is signed (§2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. (See the sample consent form in exhibit 3–1.)

A number of items on this list deserve further explanation and are discussed under the bullets below.

- ***The purpose of the disclosure and how much and what kind of information will be disclosed***

These two items are closely related. All disclosures must be limited to information that is necessary to accomplish the need or purpose for the disclosure, and this purpose or need must be specified on the consent form. It would be improper to disclose everything in a client's file if the recipient of the information needs only one specific piece of information.

Once the purpose or need has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the specified need or purpose. That, too, must be written into the consent form.

As an illustration, if a client needs to have his or her participation in counseling verified in order to be excused from school early, the purpose of the disclosure would be "to verify treatment so that the school will permit early release," and the amount and kind of information to be disclosed would be "times and dates of appointments." The disclosure would then be limited to a statement saying, "Susan Taylor (the client) is receiving counseling at XYZ Program on Tuesday afternoons at 3 p.m."

- ***The client's right to revoke consent***

The client may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, acting in reliance on the client's signed consent, it is not required to try

Exhibit 3–1:
Consent for the Release of Confidential Information

I, _____, authorize
(Name of client)

_____
(Name or general designation of program making disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information:_____
(Nature of the information, as limited as possible)

_____

_____

☐ I understand that the program will NOT be disclosing information about my sexual orientation.

☐ I understand that the program will be disclosing information about my sexual orientation.

_____
(Client's initials)

The purpose of the disclosure authorized herein is to: _____

_____
(Purpose of disclosure, as specific as possible)

_____

I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

_____/_____
(Signature of client) (Date)

_____
(Signature of parent, guardian, or authorized representative when required)

to retrieve the information it has already disclosed.

The regulations also provide that "acting in reliance" includes the provision of services while relying on a consent form permitting disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party other than the adolescent's family that pays the bills.) Thus, a program can bill the third-party payer for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.

- ***Expiration of consent form***

The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)). Depending upon the purpose of the consented disclosure, the consent form may expire in 5 days, in 6 months, or in a longer period.

The consent form does not have to contain a specific expiration date but may instead specify an event or condition. For example, if an adolescent has been placed on probation at school on the condition that she attend counseling at the program, the consent form can be drafted to expire at the completion of the probationary period. Or, if a client is being referred to a podiatrist for a single appointment, the consent form should stipulate that consent will expire after he or she has seen "Dr. X." (See below for further discussion about making referrals.)

- ***The signature of the client (and the issue of parental consent)***

A minor must always sign the consent form in order for a program to release information even to his or her parent or guardian. The program must get the signature of a parent, guardian, or other person legally responsible for the minor in addition to the minor's signature only if the program is required by State law to obtain parental permission before providing treatment to a minor (§2.14).

In other words, if State law does not require the program to get parental consent in order to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to a minor, then parental consent is required to make any disclosures.

Note that the program must always obtain the minor's consent for disclosures and cannot rely on the parent's signature alone. (For a full discussion of this issue and what programs can do when minors applying for treatment refuse to consent to parental notification in those States requiring parental consent to treatment, see "Legal and Ethical Issues," in Treatment Improvement Protocol 32 *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999c).

Where LGBT minors are concerned, the issue of parental consent can be a particularly delicate matter. Minors in States requiring parental consent for treatment can specify on the written consent form that their sexual orientation will not be disclosed to parents (see exhibit 3–1).

- ***Required notice against redisclosing information***

Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with patient consent must be accompanied by a written statement that the information is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations (§2.32).

This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier. (Of course, a client may sign a consent form authorizing a redisclosure.)

Using Consent Forms

The fact that a client has signed a valid consent form authorizing the release of information does not mean that a program must make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b)(1); 2.61(a)(b)). In most cases, the decision whether to make a disclosure authorized by a client's signed consent is up to the program, unless State law requires or prohibits a particular disclosure once consent is given. The program's only obligation under the Federal regulations is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (§2.31(c)).

In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose for disclosing the information.

- ***Using consent forms to seek information from collateral sources***

Making inquiries of families, partners, schools, employers, doctors, and other health care providers might, at first glance, seem to pose no risk to a client's right to confidentiality. But it does.

When a program that offers assessment and treatment for substance abuse asks a family member (including a parent), partner, employer, school, or doctor to verify information it has obtained from the client, it is making a disclosure that the client has sought help for substance abuse. The Federal regulations generally prohibit this kind of disclosure unless the client consents.

How then is a program to proceed? The easiest way is to get the client's consent to contact the family member (including a parent), partner, employer, school, health care facility, etc. In fact, the program can ask the client to sign a consent form that permits the very limited disclosure that he or she has sought assessment or treatment services in order to gather information from any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or name of the organization" for each collateral source the program may contact. If program staff are making inquiries by telephone, they must inform the parties at the other end of the line orally and then by mail about the prohibition on redisclosure.

Of course, the program should never disclose information about the client's sexual orientation to a collateral source, unless the client specifically consents to disclosure to that particular person or agency. The consent form provided in exhibit 3–1 allows the client to choose whether to consent to disclosure of this information.

- ***Using consent forms to make periodic reports or coordinate care***

Programs serving LGBT individuals may need to confer on an ongoing basis with other agencies, such as mental health or child welfare programs. Again, the best way to proceed is to get the client's consent (as well as parental consent when State law requires). Take care in wording the consent form to specify the purpose of the communication and the kind and amount of information to be disclosed. For example, if the program needs ongoing communications with a mental health provider, the "purpose of the disclosure" would be "coordination of care for Simon Green" and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment."

If the program is treating a client who is on probation at work and whose continued employment is contingent on completing treatment, the "purpose of disclosure" might be "to assist the patient to comply with the employer's mandates" or to "supply periodic reports about attendance," and "how much and what kind of information will be disclosed" might be "attendance" or "progress in treatment."

Note that the kinds of information that will be disclosed in these two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if that would help in coordinating care. Disclosure to an employer should be limited to a brief statement about the client's attendance or progress in treatment. Disclosure of detailed clinical information to an employer would, in most circumstances, be inappropriate.

The program should also give considerable thought to the expiration date or event the consent form should contain. For coordinating care with a mental health program, it might be appropriate to have the consent form expire when treatment by either agency ends. A consent form permitting disclosures to an employer might expire when the client's probationary period ends.

Programs should exercise great care about sharing information about clients' sexual orientation. Disclosure of such information might be therapeutically important when a substance abuse program is coordinating a client's care with a mental health provider. It would not be appropriate to disclose this information to a client's employer. Programs should get clients' consent in writing before making any disclosures about sexual orientation.

- ***Using consent forms to make referrals***

Programs treating LGBT individuals may need to refer clients to other health care or social service agencies. The program can, of course, give the client the name and telephone number of an outside gynecologist, psychologist, or training program and allow him or her to initiate the call. However, if a staff member at the program makes the call to set up an appointment, he or she must keep in mind that such a call may result in disclosure that the client has a substance abuse problem. If the staff member identifies the client as attending a substance abuse treatment program, directly or by implication, the referral requires the client's consent in writing (as well as parental consent in States requiring it).

Unless the client has consented, the program should not disclose the client's sexual orientation when making a referral.

HIV and Confidentiality

Almost all States now have laws protecting information about individuals' HIV status. The laws vary widely in the strength of the protection they offer. All allow for disclosure of HIV-related information in certain circumstances. Administrators should educate themselves about the HIV confidentiality protections offered by their individual States.

Discrimination Against LGBT Individuals

In much of the United States, discrimination against individuals because of their sexual orientation is legal. Although some States have extended their laws against racial and gender discrimination to cover discrimination on the basis of sexual orientation, in most places LGBT individuals can be denied employment or fired, barred from housing, and excluded from health and social services.

LGBT individuals are disadvantaged legally in other areas as well. In most States, same-sex couples in a committed relationship are prohibited from marrying. This means that same-sex partners must make special

arrangements if they wish to bequeath their assets to each other after death. Few jurisdictions provide unmarried partners of employees the health insurance benefits married partners take for granted; even fewer require private employers to offer unmarried partners these benefits. Partners may have difficulty visiting their loved ones in hospitals that have "family only" policies. LGBT individuals are often denied the right to adopt children.

Because of the lack of protection under the law, LGBT individuals may suffer severe or painful consequences if their sexual orientation becomes known. They risk losing custody of their own children in disputes with former spouses or families of origin because of their sexual orientation. (A diagnosis of substance abuse can be yet another strike against them in such cases.) In addition, LGBT individuals can be discharged from the military if their sexual orientation becomes known.

Thus far, only one State has enacted legislation that recognizes what it terms "civil union" between two individuals of the same sex. The statute was passed in response to a decision of the Supreme Court of Vermont (*Baker* v. *State of Vermont*) finding that the State's denial of marriage licenses to same-sex couples "effectively excludes them from a broad array of legal benefits and protections incident to the marital relation, including access to a spouse's medical, life, and disability insurance, hospital visitation and other medical decisionmaking privileges, spousal support, intestate succession, homestead protections, and many other statutory protections." The court held that "the State is constitutionally required to extend to same-sex couples the common benefits and protections that flow from marriage under Vermont law."

The Vermont Supreme Court did not order the State to offer marriage licenses to same-sex couples. Rather it required the State legislature to "craft an appropriate means of addressing this constitutional mandate [through any one] potentially constitutional statutory scheme from other jurisdictions [that provide] an alternative legal status to marriage for same-sex couples, impose similar formal requirements and limitations, create a parallel licensing or registration scheme, and extend all or most of the same rights and obligations provided by the law to married partners." Ultimately, the State legislature chose to enact a "civil union" (cu) statute, and same-sex couples in Vermont have already been "cu'ed." (It remains unclear whether other States will recognize such unions between individuals who travel to Vermont for the purpose of being cu'ed.)

The Vermont Supreme Court based its decision squarely on the common benefits clause of the Vermont constitution, a provision it interpreted as offering stronger protection to Vermont citizens than the Federal equal protection clause. The advantage of the court's resting its decision on the Vermont constitution is that the U.S. Supreme Court cannot review or overturn the decision. The disadvantage is that other States lacking a similar clause are less likely to adopt the court's reasoning.

For up-to-date information on the laws regarding discrimination against LGBT individuals, see www.lambdalegal.org.

What Can Be Done To Help LGBT Clients?

There are a number of ways that programs can adjust their policies and procedures to protect clients, educate them, and help them deal with the discrimination they may face.

1. Confidentiality

Programs should establish written policies that ensure that information about sexual orientation is confidential. The policy should prohibit disclosure of such information to anyone outside the program, unless the client

consents. Any exceptions to this rule should be approved in advance by the program director.

2. Caution on Self-Disclosures

As part of the recovery process, substance abuse treatment programs often encourage clients to acknowledge to others that they have abused alcohol and drugs. Of course, disclosure of this information is not always advisable. While there are laws protecting alcoholics and former drug abusers from discrimination in employment, housing, and access to health care (see below), it is not always easy to enforce those legal protections. Clients should be advised to think carefully before disclosing information about their substance abuse histories.

LGBT clients should also be cautioned to think carefully before disclosing their sexual orientation to others. Such disclosures will rarely be advisable unless clients are fairly sure how the information will be received. Because LGBT clients often have no legal protection against discrimination on the basis of sexual orientation, they should continue to share this information only with those they are confident will respect them and their privacy.

3. Education

Programs should educate staff and clients about State and local laws and regulations regarding LGBT persons. Some jurisdictions have enacted statutes protecting LGBT individuals from some forms of discrimination. Other jurisdictions have enacted statutes designed to make life more difficult for LGBT individuals. The confidentiality afforded HIV-related information also varies from place to place. Programs should use the resources listed at the end of this chapter to educate themselves and their clients about LGBT legal issues. The Web site maintained by the Lambda Legal Defense and Education Fund is particularly informative.

4. Legal Inventory

Programs can help their clients review their employment, marital, and parental statuses and assess what steps they might take to protect themselves and their rights.

Example 1: Barbara A., a 23-year-old lesbian, is contemplating a divorce. She has three young children and very much wants to retain custody. She worries that her spouse will use her sexual orientation (and/or treatment history) when the issue of child custody arises.

The program should encourage Barbara to share information about her sexual orientation and substance abuse treatment with her attorney. Depending on Barbara's relationships with her spouse and the children's grandparents, her attorney may advise her to consider seeking a negotiated custody agreement. Information about her sexual orientation (and substance abuse history) is less likely to be used against Barbara in this context than during a heated court battle.

Example 2: Harry B. is in a committed relationship with Stephen C. Harry is worried about what might happen if his high blood pressure causes him to have a stroke. What if he becomes unable to make decisions about his own medical care? He feels very strongly that he would not want to prolong his life following a massive stroke. He wonders whether Stephen will be allowed to make medical decisions for him.

The program can help Harry explore the options available to him, which may include (depending upon State law) signing "advance directives" about his health care and/or signing a legal document appointing Stephen his proxy, enabling him to make health care decisions should Harry become incapacitated. This legal document is often called a "health care proxy" or a "medical power of attorney."

Example 3: Ellen W. and Jean C. have grown old together. Ellen has a considerable fortune she inherited from her father; Jean has few assets. Ellen wants to make sure Jean will inherit her property.

State law generally controls rules of inheritance. However, in most (although not all) instances these rules can be overridden once an individual makes a will naming a beneficiary or establishes a trust for the benefit of a named individual. In this respect, LGBT individuals are no different from heterosexuals who are unmarried and have only distant blood relatives. They, too, must make a formal will or set up a trust if they do not want a third cousin to inherit their assets.

5. Respect for LGBT Clients

Programs treating LGBT individuals should take steps to ensure that staff and other clients respect the privacy, safety, and humanity of this population.

- Programs should screen staff members to ensure that they are willing to work with LGBT individuals. Written descriptions of job responsibilities should include treatment of LGBT individuals.
- Program rules should require that clients exhibit respect for one another without regard to race, gender, religion, national origin, or sexual orientation. Programs should establish grievance procedures for clients who want to complain about violation of the rules. All complaints should be handled promptly.
- Programs should treat the partners of LGBT clients as they do members of traditional families. Many LGBT clients are alienated from their families of origin and will not want them to visit. However, visits by a partner may be welcomed.

For a comprehensive list of "Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual, and Transgendered Clients," see the Web site maintained by the Gay, Lesbian, Bisexual, and Transgender Health Access Project at www.glbthealth.org.

6. Program Safety for LGBT Individuals

All clients should be informed at admission that the program will not tolerate sexual harassment or sexual overtures between persons of the same or different gender. Programs should establish effective grievance procedures and respond to any violations of the rules promptly.

Written personnel policies should include prohibition of harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment between persons of the same (or different) gender. Programs should establish effective disciplinary procedures and respond to complaints promptly.

Programs treating minors should be particularly attentive to this issue, as an incident involving a minor can result in serious legal consequences. The minor's parents may sue a program that is negligent in this area, and child protective services may intervene if there is an allegation of abuse.

7. Affirmative Action/Cultural Competency

Providing effective treatment for LGBT individuals requires programs to make every effort to employ LGBT individuals in visible jobs. Personnel policies should include a nondiscrimination hiring clause that encompasses LGBT persons (see chapter 14, Policies and Procedures), and programs should offer domestic partner benefits whenever possible.

Do LGBT Individuals in Substance Abuse Treatment Have Any Legal Protections?

Yes, in areas unrelated to sexual orientation, they do. The Federal Rehabilitation Act (29 U.S.C. §791 *et seq.* (1973)) and the Americans with Disabilities Act (ADA) (42 U.S.C. §12101 *et seq.* (1992)) prohibit discrimination against individuals with "disabilities," a group defined as including individuals who are alcoholics or have a history of drug abuse. Together, these laws prohibit discrimination based on alcoholism or a history of drug abuse in the services, programs, or activities provided by:

- State and local governments and their departments, agencies, and other instrumentalities (29 U.S.C. §794(b) and 42 U.S.C. §§12131(1) and 12132)

- Most providers of "public accommodations," including hotels and other places of lodging, restaurants and other establishments serving food or drink, places of entertainment (movies, stadiums, etc.), places the public gathers (auditoriums, etc.), sales and other retail establishments, service establishments (banks, beauty shops, funeral parlors, law offices, hospitals, laundries, etc.), public transportation depots, places of public display or collection (museums, libraries, etc.), places of recreation (parks, zoos, etc.), educational establishments, social service centers (day care or senior citizen centers, homeless shelters and food banks, etc.), and places of exercise and recreation (42 U.S.C. §§12181(7) and 12182).

The Rehabilitation Act and ADA (Rehabilitation Act and key implementing regulations: 29 U.S.C. §793 and 29 CFR Part 1630; §794(a), (b)(1), (b)(3)(A) and 45 CFR Part 84; Americans with Disabilities Act and key implementing regulations: 42 U.S.C. §§12111(2) and (5) and 12112 and 28 CFR Part 35, Subpart C, and 29 CFR Part 1630) also provide protection against discrimination by a wide range of employers, including:

- Employers with Federal contracts worth more than $10,000

- Employers with 15 or more employees

- Federal, State, and local governments and agencies

- Corporations and other private organizations and individuals receiving Federal financial assistance

- Corporations and other private organizations and individuals providing education, health care, housing, or social services and parks and recreation sites

- Labor organizations and employment committees.

The Rehabilitation Act and ADA also classify individuals with HIV/AIDS as individuals with disabilities and prohibit employers, government agencies, and places of public accommodation from discriminating against them on the basis of seropositivity. Because gay men, other men who have sex with men, and injection drug users constitute the largest portion of persons diagnosed with AIDS in the United States, this protection is important. For a detailed discussion of the scope of protection offered and how these statutes have been applied in cases of individuals with HIV/AIDS, see Treatment Improvement Protocol 37 *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000), available from SAMHSA's NCADI at 800–729–6686. Many States also have laws protecting people with HIV/AIDS from discrimination. Local HIV/AIDS and gay and lesbian advocacy groups and resource centers are often able to provide information and advice about both Federal and State laws in this area.

These laws can be helpful to LGBT clients and the programs treating them. If a program refers a client to a vocational rehabilitation training program or a dentist and he or she is rejected because of a history of drug abuse or HIV positivity, there is legal recourse. Programs should also be aware that they, too, are most likely covered by these laws; for example, they may not discriminate against clients with HIV/AIDS or against job applicants or employees with HIV/AIDS or histories of substance abuse.

(Note that ADA specifically excludes "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, and other sexual behavior disorders" from the definition of "disability." Psychoactive substance use disorders resulting from current illegal use of drugs are also excluded.)

Case History #1

Bill is a 41-year-old African-American man who has applied for admission to an inpatient alcohol treatment facility. Bill's history of substance abuse goes back 20 years but includes several years of sobriety and active participation in Alcoholics Anonymous. He is in a committed relationship with Harold (36), his partner of 5 years. Bill's wife died of a drug overdose 3 years ago, and he has custody of his two young children, Melissa (6) and Philip (4). The children live with Bill and Harold in their rented townhouse. Bill's late wife's parents have never accepted him and have always blamed Bill for their daughter's drug problems.

Bill has been teaching seventh grade English for the past 10 years. Only a very few colleagues in the school system know about his sexual orientation and his relationship with Harold. Bill was referred to the treatment facility by the school district's Employee Assistance Program (EAP); his employer-provided Health Maintenance Organization (HMO)-based health insurance will cover his treatment. He must satisfactorily complete treatment to retain his job. Bill has signed a form consenting to disclosures about his progress in treatment to the district's EAP.

What legal issues does this case present?

1) Disclosures of treatment information to the district's EAP: Bill should sign a consent form that complies with 42 CFR Part 2 so that the facility can release information to the district's EAP about his progress in treatment. The consent form should be limited to disclosure of general assessments of Bill's progress in treatment. Giving the EAP detailed treatment information would not be appropriate and should not be authorized by the consent form Bill signs. There should be no disclosure of any information about Bill's sexual orientation or his living arrangements. Public school systems are generally reluctant to employ an openly LGBT person. Disclosure of this information could result in Bill's losing his job (and his health insurance). Bill should sign a consent form that gives him the option of permitting or prohibiting disclosure of this information (see exhibit 3–1).

Continued ⟶

2) Disclosures of treatment information to the district's HMO: The HMO will require information about Bill's need for treatment in order to make a decision about covering that treatment. It will also demand that the facility update the information periodically. Bill must sign a consent form to permit the program to disclose information to the HMO. Disclosures to the HMO should be as limited as possible, but this may prove difficult. Many managed care organizations require programs to submit detailed information periodically before they will authorize continued treatment (or benefits). Bill has every reason to be concerned that his admission to treatment may trigger a flow of information that might, through school reviews of personnel or HMO records, result in his losing his job. The Federal rules prohibit HMOs from redisclosing information to the district, but there is no assurance that the HMO will refrain from doing so. Therefore, and although this can be difficult, there should be no disclosure of any information to the HMO about Bill's sexual orientation or his living arrangements. Bill should sign a consent form that gives him the option of permitting or prohibiting disclosure of this information (see exhibit 3–1).

3) Disclosure of information about Bill's sexual orientation to his in-laws: Disclosure could spark an attempt to challenge Bill's custody of his children. In many States, the combination of Bill's sexual orientation and his history of alcohol abuse could be used by relatives to try to wrest custody from him. If Bill's in-laws do file a court case seeking custody and their attorney issues a subpoena for Bill's treatment records, the program can, working with Bill's attorney, ask the court to issue an order restricting the scope of the information the program will be required to provide. For detailed information on dealing with subpoenas and court orders, see Treatment Improvement Protocol 24 *A Guide to Substance Abuse Treatment for Primary Care Clinicians* (CSAT, 1997a), available from SAMHSA's NCADI at 800–729–6686.

What policy issue does this case present?

How will Harold be listed on the intake form: as "spouse" and/or next of kin?

Facilities may set their own individual policy about how they treat life partners. At the very least, programs should allow clients to sign a consent form specifying whom the program can call in emergencies.

Case History #2

Denise is a 16-year-old white female who entered an inpatient treatment program after being hospitalized twice: once for alcohol poisoning and once after a suicide attempt. Denise's parents are working professionals with a comfortable income and large home in the suburbs. Denise has been living at home but does not get along with her two older sisters or her younger brother. She has been habitually truant.

Denise has confided in her counselor that for some time she has been having a hard time with her attraction to and feelings about other girls. Denise characterizes her parents as homophobic and is terrified about what might happen if they find out. Once, when her father found her watching an episode of the TV program "Ellen," he screamed at her: "Why would you want to watch that disgusting smut? I will not have that stuff in my house!"

Denise has signed a consent form permitting her counselor to speak with her parents about her substance abuse treatment.

After Denise has been in the program for a month, a staff member discovers her acting out sexually with another girl.

Continued ⟶

What legal issues does this case present?

1) Does the facility have to tell Denise's parents about her sexual attraction to other girls? No. Denise has consented to communications with her parents about her substance abuse treatment. Denise's fears about her parents' reaction may be entirely realistic. Disclosure of this information to Denise's parents at this time would certainly destroy any therapeutic relationship developing between Denise and her counselor. Such disclosure may also be a violation of professional ethics.

   Now that Denise's counselor knows Denise's concern, she could ask her to sign a new consent form that specifically requires the program to withhold information about her sexual orientation from her parents (see exhibit 3–1).

2) Can Denise's counselor discuss her discovery with other facility staff? Yes, the counselor can discuss her discovery with other program staff. The Federal confidentiality regulations contain an exception permitting communication of information between or among program staff members who have a need for the information in connection with their treatment responsibilities.

3) Should Denise's counselor discuss her discovery with other staff? Yes, the counselor should tell other staff, including the program director, about her discovery. The sexual acting out may have affected either Denise or the other girl, and failure to disclose it might create a legal risk for the program.

   - If one girl makes an unwanted advance to another girl, the program has a responsibility to help the victimized child. The information is important to the other girl's treatment counselor. He or she should be working with the girl to help her cope with this experience.

   - The information is also important to the program director. If the other girl was an unwilling target or participant, her parents might sue the program for failing to protect their child. Moreover, if such an incident is swept under the rug, the aggressor may act out again, in which case the program could be put in real jeopardy.

What policy issues does this case present?

1) Program rules regarding client behavior. If the program does not have rules about sex between clients, it should adopt rules now. If the program does have rules, the treatment staff and the program director should discuss whether the acting out violated any program rules and, if so, what the program should do.

2) Preventive measures. The program director should consider whether the program can take additional steps to ensure such incidents do not occur in the future.

Case History #3

Frankie is a 66-year-old retired postal worker who has been in and out of 12-step programs and outpatient treatment for 10 years. This will be his first inpatient treatment episode. Frankie came to the intake session with Janice, his female partner of 16 years. The couple lives together in a home they purchased 12 years ago. They are not legally married, but their friends and family consider them husband and wife. They have two grown children (one each from previous marriages) and five grandchildren. Frankie expects that Medicare will pay for his treatment. Janice works for the city and is covered by the city's HMO plan.

After intake, Frankie is settled in a room with another male patient. On Frankie's first night at the facility, a nurse observes that Frankie has female genitals. Frankie's roommate demands that he be moved out of the room. The nurse has told her supervisor that she's not going to work "with that 'weirdo' in Room 112."

What legal issues does this case present?

1) Who is responsible for the cost of Frankie's care? Since Frankie and Janice are not legally married, and cannot be, Janice is not responsible for the cost of Frankie's treatment. Janice may want to support part of the costs of treatment, but there is no legal requirement that she do so, and unless her employer provides health benefits to domestic partners, her HMO will not contribute.

2) Will Medicare cover Frankie's treatment if his declared gender is not in accord with his biological sex? Ask Frankie whether Medicare identifies him as male or female. If he gives a different gender from what appears on the original Medicare application, there may be problems with payment.

3) Who is considered "next of kin"—Janice? or Frankie's child? Since Frankie's and Janice's relationship is not State sanctioned, Frankie's child is considered his next of kin. However, if Frankie would prefer to name Janice as his next-of-kin for visiting and emergency-notification purposes, the program should respect his wishes.

4) Can the program fire staff who refuse to work with Frankie because he is transgendered? Yes. Unless the staff person is protected by a union contract with a provision covering this situation, he or she can be fired at any time, unless the action is taken because he or she is female, a member of a minority group, or disabled. In the United States, most employment is "at will," which means that either the employer or employee can end the relationship at any time and for any reason, unless that reason violates one of the civil rights statutes discussed above.

What policy issues does this case present?

1) What policies should the program have in place to ensure that LGBT individuals are treated fairly? Programs should have written policies in place that require staff to be willing to treat all clients without regard to race, gender, disability, or sexual orientation. Job descriptions should make treatment of clients (regardless of their status) an integral part of the responsibilities of each position. Staff should be screened before hiring to ensure they are willing to abide by the program's treatment rules and should be required to attend educational and sensitivity training about LGBT individuals.

2) Should the program move Frankie away from his objecting roommate? Yes. No one should have to endure a hostile roommate. Moving Frankie avoids a difficult situation and helps with his treatment. With Frankie's consent, the program should conduct a sensitivity session to educate clients about transgendered individuals as well as those who are lesbian, gay, or bisexual.

Recommendations

The following are some recommendations for improving substance abuse treatment for LGBT clients.

1. Improve knowledge among staff members about the laws affecting LGBT individuals with substance abuse histories. These include:

   a. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to alcoholics and individuals with histories of drug abuse

   b. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to individuals with HIV/AIDS

   c. Federal confidentiality laws and regulations

   d. State laws protecting HIV-related information

   e. State and local laws that apply to LGBT individuals.

2. Ensure that staff members respect LGBT clients by:

   a. Establishing written job descriptions that require treatment of all clients without regard to their sexual orientation

   b. Screening out job applicants who express overt bias

   c. Establishing clear, written program policies requiring equal treatment of clients without regard to their sexual orientation and enforcing program policy through a disciplinary process

   d. Providing staff members with training to increase their awareness of and sensitivity to LGBT issues

   e. Establishing a procedure for clients to complain about bias.

3. Ensure that clients respect LGBT individuals by:

   a. Establishing program rules requiring respect for clients without regard to their race, gender, religion, national origin, or sexual orientation

   b. Providing clients with education and information about LGBT individuals

   c. Establishing grievance procedures for clients wishing to lodge complaints

   d. Enforcing program rules promptly.

4. Ensure that LGBT staff and clients are safe while attending the program by:

   a. Establishing personnel policies prohibiting harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment by persons of the same or a different gender

   b. Informing clients at admission that the program does not tolerate sexual harassment or sexual overtures or activities by persons of the same or a different gender

   c. Enforcing the rules promptly

   d. Establishing grievance procedures for both staff and clients who may wish to complain about harassment and responding promptly to complaints.

5. Take all steps necessary to ensure the confidentiality of information about clients' substance abuse treatment as well as their sexual orientation by:

   a. Providing staff with training about the Federal confidentiality regulations

   b. Establishing written policies about the confidentiality of information about sexual orientation and instructing staff about those policies

   c. Educating clients about the importance of respecting the confidentiality of their fellow clients.

6. Establish personnel policies that attract and retain LGBT staff by:

   a. Actively recruiting such individuals

   b. Offering such individuals' partners the same benefits offered married couples.

7. Educate LGBT clients about:

   a. The confidentiality protections they enjoy (and those they lack)

   b. The antidiscrimination laws that protect them, as well as the ways in which their rights are not protected

   c. The steps they can take to protect themselves.

Resources

Confidentiality of Substance Abuse Treatment Records

Confidentiality of Patient Records for Alcohol and Other Drug Treatment. Technical Assistance Publication (TAP) 13 (CSAT, 1994b), 36 pp. BKD156.

This guide provides an overview of Federal alcohol and drug treatment confidentiality laws and regulations as well as options for dealing with a wide variety of situations. The appendix includes sample forms for patient consent and qualified service organization agreements. (Although the printed version of this publication is currently out of stock, it can be viewed and printed from PREVLINE, at www.health.org.)

Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance. TAP 18 (CSAT, 1996), 52 pp. PHD722X.

This TAP is a reference for the substance abuse treatment provider on maintaining and protecting patient confidentiality and records.

Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need To Know and Privacy. TAP 24 (CSAT, 1999d), 40 pp. BKD336.

This report provides guidance for alcohol and drug treatment providers on resolving confidentiality issues that arise in the context of welfare reform.

Legal Issues Associated With Development and Implementation of a Provider-Sponsored Managed Care Organization. Volume 6 (SAMHSA, 1998), 65 pp. BKD296.

This publication summarizes the legal issues that substance abuse treatment service and mental health providers address in organizing provider-sponsored managed care organizations (MCOs) and implementing managed care programs through contract negotiation and the delivery of services and care through provider contracts.

Legal Action Center
153 Waverly Place
New York, NY 10014
Ph: 800–223–4044
www.LAC.org

The Legal Action Center is the only law and policy organization in the United States that fights discrimination against people with histories of addiction, AIDS, or criminal records and advocates for sound public policies in these areas. The center provides:

- Legal services, including impact litigation
- Policy advocacy and research
- Training, technical assistance, and education.

LGBT Rights

A Legal Guide for Lesbian and Gay Couples (10th Ed.) (Curry et al., 1999).

This manual outlines the differences between legally married couples and same-sex partners.

Advocates for Youth
1025 Vermont Avenue, NW, Suite 200
Washington, DC 20005
Ph: 202–347–5700, Fax: 202–347–2263
www.advocatesforyouth.org

Advocates for Youth (formerly Center for Population Options) is dedicated to creating programs and promoting policies that help young people make informed and responsible decisions about their sexual and reproductive health. It provides information, training, and advocacy to youth-serving organizations, policymakers, and the national and international media. Advocates for Youth also sponsors the Youth Resource Web site at www.youthresource.com (for LGBT youth).

American Civil Liberties Union (ACLU)
132 West 43rd Street
New York, NY 10036
Ph: 212–944–9800
www.ACLU.org

The American Civil Liberties Union is a nonprofit, nonpartisan, 275,000-member public interest organization devoted exclusively to protecting the civil liberties of all Americans and extending those rights to groups that have traditionally been denied them. It files court cases to expand and enforce individuals' civil rights and educates legislatures and the public on a broad array of issues affecting individual freedom in the United States.

ACLU Lesbian and Gay Rights Project
125 Broad Street
New York, NY 10004
Ph: 212–549–2627

The goal of the ACLU Lesbian and Gay Rights Project is equal treatment and equal dignity for lesbians, gay men, and bisexuals. That means even-handed treatment by the government; protection from discrimination in jobs, housing, hotels, restaurants, and other public places; and fair and equal treatment for lesbian and gay couples and families.

Human Rights Campaign (HRC)
919 18th Street, NW
Washington, DC 20006
Ph: 202–638–4160, Fax 202–347–5323
www.hrc.org

HRC is the largest national lesbian and gay political organization. Its mission is to create an America where lesbian and gay people are assured of basic equal rights and where they can be open, honest, and safe at home, at work, and in the community. With a national staff and volunteers and members throughout the country, HRC:

- Lobbies the Federal Government on gay, lesbian, and AIDS issues
- Educates the public
- Participates in election campaigns

- Organizes volunteers
- Provides expertise and training at the State and local levels.

Lambda Legal Defense and Education Fund
120 Wall Street, Suite 1500
New York, NY 10005–3904
Ph: 212–809–8585, Fax: 212–809–0055
www.lambdalegal.org

Lambda is the Nation's oldest and largest legal organization working for the civil rights of lesbians, gay men, and people with HIV/AIDS.

National Center for Lesbian Rights (NCLR)
870 Market Street, #510
San Francisco, CA 94103
Ph: 415–392–6257, Fax: 415–392–8442
www.NCLRights.org

NCLR is committed to advancing the rights and safety of lesbians and their families through litigation, public policy advocacy, free legal advice and counseling, and public education. NCLR also provides representation and resources to gay men and bisexual and transgendered individuals on key issues that affect lesbian rights.

National Gay and Lesbian Task Force (NGLTF) (Main office)
1700 Kalorama Road, NW
Washington, DC 20009–2624
Ph: 202–332–6483, Fax: 202–332–0207
TTY: 202–332–6219

National Gay and Lesbian Task Force (Policy Institute)
121 West 27th Avenue, Suite 501
New York, NY 10001
Ph: 212–604–9830, Fax: 212–604–9831
www.ngltf.org

NGLTF is a leading progressive civil rights organization that has supported grassroots organizing and advocacy since 1973. Since its inception, NGLTF has been at the forefront of every major initiative for lesbian, gay, bisexual, and transgender rights. In all its efforts, NGLTF works to strengthen the gay and lesbian movement at the State and local levels while connecting these activities to a national vision of change.

Servicemembers Legal Defense Network
P.O. Box 65301
Washington, DC 20035–5301
Ph: 202–328–3244, Fax: 202–797–1635
www.sldn.org

On July 19, 1993, the Clinton administration announced a new policy regarding gays in the military. Dubbed "Don't ask, don't tell, don't pursue," the policy was intended to stop military officials from asking troops about their sexual orientation, end witch hunts, and stop harassment of lesbian and gay service members. Suspect service members still face an untimely end to their careers. Most service members do not realize that the new policy affords little protection or privacy for lesbian and gay personnel, and most service members do not know what their legal rights are under the new policy.

It's Time, America! (ITA!)
www.gender.org/ita/

ITA is the first nationally organized grassroots civil rights group seeking to secure and safeguard the rights of all transgender individuals. The mission of It's Time, America! is to educate and influence the U.S. Congress, State and local governments, and transgender and nontransgender political organizations on the issues and concerns of transgender people and to take steps to safeguard and secure their rights as American citizens.

Queer Resources Directory
www.qrd.org
Queer Legal Resources
www.qrd.org/www/legal/

The *Queer Resources Directory* contains tens of thousands of files about various topics of interest to LGBT individuals. It bills itself as having one of the most extensive collections of materials devoted to LGBT legal issues on the Internet. The collection includes:

- Tables listing the important legal cases dealing with LGBT and AIDS issues for each year from 1992 to the present
- Case and issue archives by subject
- Statewide gay rights statutes and same-gender marriage resources
- *Lesbian/Gay Law Notes*, edited by Professor Arthur Leonard, a monthly summary of the cases important to gay/lesbian and HIV/AIDS jurisprudence
- *National Journal of Sexual Orientation Law*, an electronic legal journal devoted to sexual orientation and the law
- QueerLaw and QueerLaw-Digest, with information about companies with nondiscrimination policies that include sexual orientation; companies and organizations that provide domestic partner benefits; States that criminalize sexual acts between people of the same gender; State laws on age of consent for sexual acts between people of the same gender; and sodomy and age-of-consent laws worldwide
- Lists and links to groups that work on legal issues of interest to LGBT individuals.

Gay, Lesbian, Bisexual and Transgender Health Access Project
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The Gay, Lesbian, Bisexual and Transgender Health Access Project is a collaborative, community-based program funded by the Massachusetts Department of Public Health. The Project's mission is to foster the development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care services for gay, lesbian, bisexual, and transgendered people and their families.

Chapter 4 Overview of Treatment Approaches, Modalities, and Issues of Accessibility in the Continuum of Care

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What providers will learn from this chapter:

- The special issues that need to be addressed in working with LGBT individuals
- The levels of care and the types of treatment that appear to work best for LGBT individuals
- The major issues of accessibility related to substance abuse treatment for LGBT populations
- How a program can be made accessible for LGBT populations

Introduction

This chapter advises providers on approaches, modalities, and accessibility in the continuum of care relevant to the lesbian, gay, bisexual, and transgender (LGBT) populations seeking substance abuse treatment services. Although the issues discussed may be similar to those of the larger population, some differences exist. This chapter provides information about accessibility and attributes of programs that are helpful for LGBT clients.

Substance abuse treatment for LGBT individuals is the same as that for other individuals and primarily focuses on stopping the substance abuse that interferes with the well-being of the client. However, some LGBT clients will need to address their feelings about their sexual orientation and gender identity as part of their recovery process. For some LGBT clients, this will include addressing the effects of internalized homophobia. Clinicians sometimes see relapses in LGBT persons with lingering negative feelings about their sexual orientation or gender identity.

Substance use, especially alcohol use, is woven into the fabric of the lives of many LGBT individuals. The greater use and presence of alcohol and drugs in settings where LGBT people socialize (in conjunction with the denial produced by the use of these substances) may help to explain the greater predisposition to substance abuse among LGBT individuals.

Even if the LGBT individual is open about his or her identity, it is virtually impossible to deny the effects of society's negative attitudes, which can result in feelings of doubt, confusion, fear, and sorrow (Diamond-Friedman, 1990). Often referrals or appropriate treatment are difficult to secure due to the lack of understanding of these issues by treatment program administrators and staff. Finding a program that can both address LGBT clients' treatment needs and be supportive of them as individuals can be very difficult.

Members of the LGBT community often face problems in traditional health care systems and are stigmatized within programs by staff and other clients (Mongeon & Ziebold, 1982). Service providers should develop a basic understanding of how they can best serve these populations to help ensure successful treatment outcomes. In addition, due to the multicultural and varied backgrounds of LGBT clients, treatment approaches and modalities may need to be tailored to meet the needs of these individuals.

The growing body of literature on working with LGBT substance abusers can help clinicians understand the issues and improve treatment (Cabaj, 1996; Finnegan & McNally, 1987; Gonsiorek, 1985; Ziebold & Mongeon, 1985).

Approaches

Abstinence-based and treatment-readiness approaches to substance abuse disorders are the two major approaches presented in this chapter. For the purpose of this publication, treatment readiness refers to the level of readiness that individuals may exhibit relating to changing alcohol and drug use behaviors. When undergoing treatment for substance abuse, LGBT individuals have many of the same issues as the larger population, but they may have additional issues as well. LGBT clients may be coping with coming out; their sexual orientation and gender identity; societal stigmas; HIV/AIDS; death and dying; discrimination; same-sex relationships; and homophobic family members, employers, and work colleagues. At times, these issues have a negative impact on a person's ability to change his or her alcohol and drug use patterns and other harmful behavior.

Providers need to understand that a part of substance abuse recovery for many LGBT individuals is accepting themselves as gay, lesbian, bisexual, or transgender and finding a way to feel comfortable in society.

Levels of Care

Levels of care refers to the intensity and duration of services being provided by a program to clients, including inpatient, residential, therapeutic, partial hospitalization or day treatment, intensive outpatient, outpatient, aftercare and followup, and monitoring services.

LGBT substance abusers should be assessed to determine the range of services and levels of care they require. The type of drug and the amount used by a client, the danger of a medically complicated withdrawal, the difficulty with withdrawal and craving, and the need to be away from social and psychological stressors will help a counselor determine the level of care a client needs. Whatever the planned treatment, it should be LGBT sensitive and supportive.

Although they abuse alcohol and some of the same substances as non-LGBT substance abusers, certain LGBT individuals may abuse other drugs that influence the level and duration of care they need. For example, methamphetamine abuse is nearly epidemic in gay men in some parts of the United States (Freese et al., 2000). Abuse of this drug often results in strong cravings and frequent relapses and may require extensive and highly focused treatment.

Outpatient care will serve the vast majority of LGBT substance abusers, just as it does non-LGBT substance abusers. Many larger urban communities have residential programs for LGBT people as well as LGBT-supportive inpatient or outpatient recovery programs.

Continuum of Care

The continuum of care refers to continuing available services and may include provision of additional services while individuals are in the program; ongoing support and services after discharge (regardless of treatment completion); followup and monitoring activities; and outreach, recruitment, and retention. Some of these services may be different for LGBT clients due to factors such as the health status of the clients or their partners, their living arrangements, the type and stability of their employment, their work hours, their level of openness about their sexual orientation/ sexuality, and their experience with previous service providers or systems.

Accessibility

Due to the homophobia and discrimination they experience, LGBT individuals may find it difficult, and sometimes uncomfortable, to access treatment services. Substance abuse treatment programs are often not equipped to meet the needs of this population. Heterosexual treatment staff may be either uninformed about LGBT issues, insensitive to their concerns, or antagonistic toward such individuals. These attitudes may be based on misperceptions or personal beliefs. A harmful result of this insensitivity is that some professionals or other clients may falsely believe that an LGBT person's sexual orientation/gender identity caused his or her alcohol and drug use. One's sexual orientation/gender identity should not be viewed as in need of changing. Such factors become barriers when the LGBT population seeks access to appropriate treatment.

Some LGBT individuals may express difficulty in participating in non-LGBT focused treatment, stating that heterosexuals may not understand LGBT issues and problems. This can be problematic for the treatment staff, but it does not have to impede services. This attitude may be a defense mechanism, or the person may have experienced problems with heterosexual treatment providers in the past. Whatever the cause, it should be managed in a therapeutic manner. Encourage individuals to discuss previous experiences or why they have these feelings or attitudes toward heterosexuals. It is also important for counselors not to assume that they know why such statements are made or that they completely understand these experiences. Be sensitive to the LGBT individual's experience and facilitate these issues within a therapeutic context.

Often negative feelings or attitudes are based on real experiences and should be acknowledged as such. Making the program accessible to the LGBT community may require some changes. Programs that use observers to administer urine screens need to consider the clients' concerns and ask which gender observer they prefer. Staff may not know what gender the client considers herself or himself, and this could result in uncomfortable situations.

If possible, designate a separate, non-gender-specific toilet and shower facility for some LGBT clients, particularly in residential treatment settings. Transgender individuals may be in the process of change or may be living as the gender opposite the one they were born with, which may result in these individuals using rest rooms different from what one would expect.

Heterosexual staff and clients should not assume that LGBT individuals are any more likely to flirt or act out sexually than their heterosexual counterparts. Rules regarding sexual interactions, flirting, and dating in treatment settings should be the same for LGBT persons as for heterosexual individuals.

Degrees of LGBT Sensitivity

In addition to addressing issues of accessibility, it is important for program administrators and staff to create a supportive environment for LGBT individuals. The impact on the client of anti-LGBT bias and internalized homophobia should be considered when developing the treatment plans of LGBT people with substance abuse problems. Few programs provide education to staff about LGBT people, and many programs may be unaware that they have LGBT clients. Some LGBT clients may be too frightened to come out during treatment or feel they have been given permission to be open about their sexual identity (Hellman et al., 1989). Staff attitudes are crucial in helping clients feel comfortable and safe; training counselors about homosexuality will help clients feel safe.

Substance abuse treatment programs can be rated on a spectrum from LGBT-hostile to LGBT-affirming. Exhibit 4–1, which was adapted from Neisen (1997), provides a brief overview of the components identified on the spectrum.

It is hoped that only a few programs are openly hostile toward LGBT people; it is essential that any LGBT individuals seeking help for substance abuse problems are not treated at these programs. Unfortunately, many substance abuse treatment programs are unaware of the importance of sexual orientation and operate as if everyone is heterosexual—unaware that LGBT people exist. In such settings, LGBT people most likely will not talk about their sexual orientation or gender identity and will not be able to integrate their sexuality and acceptance of a gay, lesbian, bisexual, or transgender identity into recovery. Internalized homophobia/transphobia and coping with anti-LGBT societal bias most likely will not be discussed.

Some substance abuse treatment programs may be **LGBT tolerant**, that is, aware that LGBT people exist and use their services. Such awareness is usually due to an LGBT staff member. Even so, accepting one's sexual orientation and dealing with homophobia most likely will not be addressed.

LGBT-sensitive programs are aware of, knowledgeable about, and accepting of LGBT people. Many well-established programs are training staff about LGBT concerns to make them LGBT sensitive. The material in this document is part of that effort. LGBT-sensitive programs acknowledge the existence of LGBT people and treat them with respect and dignity. These programs usually care for LGBT people in the same way that they treat other clients but recognize the difficulties and challenges facing LGBT people in recovery. Some programs may also have specific therapy groups for LGBT people.

Fewer programs are **LGBT affirmative**—that is, they actively promote self-acceptance of an LGBT identity as a key part of recovery. These programs affirm LGBT individuals' sexual orientation, gender identity, and choices; validate their values and beliefs; and acknowledge that sexual orientation develops at an early age. An LGBT-affirmative program, the Pride Institute, released data showing a very successful treatment rate when acknowledging one's sexual orientation is considered a key factor in recovery (Ratner, Kosten & McLellan, 1991). At a 14-month followup with verified reports, 74 percent of all patients treated 5 or more days abstained from alcohol use continuously, and 67 percent abstained from all drugs. These data can be compared with data from four similar, sometimes LGBT-sensitive but non-LGBT-affirmative treatment programs with unverified reports taken at followups ranging from 11 months to 24 months after treatment, which had abstinence rates of 43, 55, 57, and 63 percent.

Exhibit 4–1:
LGBT Sensitivity Model

Anti-LGBT Treatment	Traditional Treatment	LGBT-Naive Treatment	LGBT-Tolerant Treatment	LGBT-Sensitive Treatment	LGBT-Affirming Treatment
No LGBT sensitivity	No LGBT sensitivity	No LGBT sensitivity	Minimal LGBT sensitivity	Moderate level of LGBT sensitivity	Highest level of LGBT sensitivity
Antagonistic toward LGBT individuals	No realization that there are LGBT clients	Realization that there are LGBT clients	Recognition that there are LGBT clients	Several clients and/or staff are open with their LGBT identity	Program primarily targets LGBT population
Treatment focuses exclusively on heterosexuals and excludes LGBT clients	No acknowledgment or discussion of LGBT issues; it is assumed everyone is heterosexual	As an agency, has not yet begun to address the special issues of the LGBT population	Some staff may verbalize that it is okay to be an LGBT individual; however, such discussions are limited to individual sessions	Several workshops and/or groups focus on LGBT issues; they may have LGBT groups or a "track" for LGBT issues; groups are generally mixed	All workshops specifically for LGBT clients; workshops and groups affirm the LGBT individual, have LGBT-specific materials, etc.; groups and workshops are not mixed with heterosexuals
No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	Some specific LGBT treatment components	All treatment components are LGBT specific

Adapted from Neisen, 1997

Specific Issues

Substance abuse and sexual identity formation, which includes awareness and acceptance of sexual orientation and gender identity, are often enmeshed for many LGBT people. Some counselors and clinicians working with LGBT clients' substance abuse see addressing these issues as essential to recovery, and failure to do so may result in a difficult recovery process.

Substance abuse treatment programs that are LGBT sensitive are more likely to have more successful outcomes with LGBT clients.

Exhibit 4–2 presents principles of care that are appropriate for any client. Program administrators and staff need to be aware of issues that may be specific to the LGBT population with respect to the continuum of care, including outreach, identifying the extent of alcohol and drug use, and discharge planning.

Exhibit 4–2:
Principles of Care

Principles of care that should be part of any substance abuse treatment program for LGBT populations are listed below. These principles are adapted from a mental health care practical guide to developing programs for working with people living with or affected by HIV/AIDS (Acuff et al., 1999).

Be flexible and client centered
Clients will present with a wide range of substance use and psychosocial needs. While some clients may benefit from group modalities, others may need individual counseling or may benefit from supportive treatment. To meet the individual's needs, services need to be flexible but consistent and thorough.

Be coordinated, integrated, and comprehensive
Service systems should establish formal linkages and networks to enhance service coordination and integration. Likewise, providers working in a multidisciplinary setting should use a team approach to meet each client's needs.

Be consistent with each client's cultural needs and expectations
Programs may need to employ multilingual and multicultural staff as well as individuals representing LGBT populations. Sensitivity training is essential for staff members who are not culturally matched with the client base.

Promote self-respect and personal dignity
Effective service delivery depends on recognizing an individual's self-worth and contributions to his or her community. Society and the traditional health care system, along with substance abuse treatment programs, typically may have stigmatized LGBT clients and left them with little sense of self-respect or dignity. Programs must ensure that staff and the service delivery system do not stigmatize the clients further.

Promote healthier behaviors
Service providers can work with clients to practice healthier behaviors, to practice safer sexual behaviors, to strengthen supportive relationships, and to comply with medication regimes for HIV and psychotropic communities—or other professionals and agencies may provide positive examples for clients currently in treatment or receiving services.

Empower persons in substance abuse treatment to make decisions in collaboration with the service provider
Service providers must not assume that they know what is best for individuals but must include clients in treatment planning. All segments of the community, including consumer and advocacy groups, should be involved in the process of establishing, delivering, and improving services.

Reduce barriers to services for hard-to-reach populations
LGBT populations are varied, which can cause difficulties in reaching segments of the community. Individuals may be homeless, work as street hustlers/prostitutes, be in jail/prisons, or come from a variety of cultural/ethnic backgrounds, thus creating the need to develop effective outreach and retention mechanisms.

Develop and deliver services that are clinically informed and research based
It is important not to assume that services that are effective for the larger population will be as effective or appropriate for the LGBT populations; clinical issues often are different and need to be acknowledged and treated. Evaluations of current clinical services for the LGBT community may need to be undertaken, or research from other such undertakings can be used to develop appropriate services.

Work to create a treatment/recovery community
Programs can play a role in developing a community of individuals, agencies, and organizations that work in partnership to develop a treatment/recovery community. Making use of individuals who have successfully completed treatment (alumni), individuals in the recovery communities, or other professionals and agencies may provide positive examples for clients currently in treatment or receiving services.

Identifying the extent of alcohol and drug use is an issue that is important to all individuals entering substance abuse treatment regardless of their sexual orientation. Traditional assessment forms may need to be modified or redeveloped for the LGBT populations to include more inclusive language (refer to Coleman's Assessment Tool in chapter 1).

Without culturally competent training, the assessor may be uncomfortable and miss biopsychosocial information important to effective treatment planning. Also, collecting collateral information may be different for the LGBT population: Some LGBT clients may not have close relationships with their family of origin; it may be clinically appropriate to gather collateral information from a partner and close friends (who may be identified by clients as their family of choice). However, it cannot be assumed that all LGBT clients are estranged from their families of origin. Many have supportive and close families. It may be helpful to include these individuals in treatment to expand clients' recovery support system.

Special Assessment Questions

In formulating a treatment plan for LGBT individuals with a substance abuse problem, some additional factors may need to be assessed. Following are a sample.

- Determine the individual's comfort with being an LGBT person. Evaluate the person's comfort level with his or her sexuality and expression of sexual feelings. If the person is a transgender individual, determine his or her level of comfort with, and acceptance of, that identity.

- If appropriate, determine the stage where the individual is in the coming-out process (whether as a gay, lesbian, bisexual, or transgender person). Learn about his or her experience and the consequences of coming out.

- Determine the extent of the individual's support and social network, including whether there are any current relationships or past relationships and the individual's relationship with his or her family of origin.

- Determine whether there are any health factors of concern, including the individual's HIV status.

The substance abuse counselor can ask the same questions about alcohol or drug use as he or she uses for non-LGBT individuals. Specific information about the patterns of, and situations involved in, the use of alcohol and drugs by LGBT individuals can be helpful in planning treatment and preventing relapse. For example:

- Look at the most recent alcohol and drug use: Was it with family, friends, a significant other, a lover, or a date? With work colleagues? Where was it? At a circuit party? Alone? At a sex club or bathhouse? At a lesbian, gay, bisexual, or transgender bar or at a straight bar?

- Is there current or past intravenous or injection drug use? If so, what drugs are used? Are amphetamines (speed, crystal, crank) used? Are amphetamines used to enhance sexual intensity?

- What is the frequency of the alcohol and drug use? Does it correlate with the socializing?

- What is the drug of choice—the drug the client enjoys or seeks most? What does it seem to do or accomplish? Provide relaxation? Provide freedom from guilt? Enhance sexual behavior?

- If the client has a significant other, does that person believe there is a problem? Does he or she have his or her own substance abuse problems?

- Has the client had legal problems due to his or her use of alcohol and drugs, including driving under the influence? Has the client ever had legal problems related to sexual behavior or police harassment?

- Has the client ever been attacked or assaulted (gay bashed) because he or she was thought to be an LGBT person?

- Has the client had social problems or lost partners, family, or friends because of alcohol and drug use? Has there been domestic violence? Was it by a same-sex lover?

- Has the client had treatment in the past for substance abuse? If so, was his or her sexual orientation or sexuality discussed?

- What is the longest time the client did without alcohol and drug use, and what allowed that to happen?

Modalities

Typical modalities for substance abuse treatment include individual, group, couples, and family counseling, but LGBT individuals can face other unique problems if they are treated by traditional programs through group, couples, or family modalities.

The group modality may be difficult for LGBT individuals if heterosexism/homophobia is demonstrated by staff and other group members. Groups should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns. If a group combines heterosexuals and LGBT individuals, provide sensitivity training relating to LGBT issues and concerns; ensure that all clients are aware that groups will be mixed. Placing LGBT individuals in therapy groups with homophobic clients may lead to difficult situations and/or hostility toward the LGBT individuals.

Staff need to ensure that LGBT clients are treated in a therapeutic manner and should provide a strong verbal directive that homophobia and hostility will not be tolerated. If it does occur, staff must take strong action on behalf of LGBT clients. LGBT clients should not be required to discuss issues relating to their sexuality or sexual orientation in mixed groups if they are uncomfortable. On the other hand, in a mixed group setting led by adequately trained, culturally competent, and LGBT-supportive staff, LGBT clients may have the powerful experience of gaining acceptance and affirmation from peers. The acceptance and care that can come from members of groups could be healing for LGBT persons.

Often, intensive programs provide groups for special populations (e.g., women, professionals, those with HIV/AIDS, racial/ethnic minorities) to address their multidimensional needs (CSAP [Center for Substance Abuse Prevention], 1994). If a program has enough LGBT clients, it may start an additional or separate group for them. This may provide a safe or more cohesive venue for discussing issues specific to LGBT clients. However, attendance should be voluntary. When LGBT- or gender-specific groups are held, therapists should regularly direct attention to safe-sex practices and sexual feelings about and experiences with same-sex individuals.

Family counseling can be difficult due to issues relating to the client's sexual identity/orientation, substance abuse, and, in some cases, HIV/AIDS diagnosis, which have caused distance and alienation. LGBT clients are more likely to seek support for their partners if they view the program as LGBT sensitive.

If a program provides treatment primarily through an individual modality, many of these issues may not be relevant. Providing one-to-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood

that heterosexism/homophobia will become an issue. LGBT individuals will be able to discuss issues revolving around their sexual orientation/identity without fearing that non-LGBT individuals will be hostile, will be insensitive, or will minimize LGBT issues.

Discharge planning

Specific concerns related to the discharge planning process for LGBT clients may include an enhanced analysis of their social support, their living arrangement/environment, their employment status or type of employment, and ongoing issues that clients have identified related to their sexual orientation/identity. Social support involves the amount of support available to clients, which can increase their likelihood of remaining abstinent or in recovery. Social support often includes the family of origin and family of choice (e.g., sexual partner, friends, or others) and should focus on individuals who support clients' efforts to create such significant changes. LGBT individuals may live in an environment that is not conducive to their ongoing abstinence/recovery (e.g., they have a partner or roommate who actively uses alcohol and drugs, or they live in close proximity to drug dealers or open air drug markets). Although these issues or concerns may be similar to those individuals from the larger population may face, it is important to assess and provide appropriate referrals for LGBT clients. Clients' employment status or type of employment may also interfere with their ongoing abstinence/recovery. Specific issues may be the type of work the individuals perform (e.g., bartender, sex industry worker) or status (e.g., not in stable employment, disabled). Issues related to their sexual orientation/identity may interfere with their recovery after discharge if ongoing support or counseling is not provided to meet needs indentified by clients.

Aftercare/Recovery

Aftercare and support for recovery may be a problem, depending on the geographic location and any difficulties the client may have expressed concerning acceptance of his or her sexual orientation (there may be no LGBT-sensitive counselors or programs in the client's community).

Twelve-step recovery programs and philosophies are, of course, the mainstays in recovery and in staying clean and sober. As an organization, Alcoholics Anonymous (AA) clearly embraces LGBT individuals as it embraces anyone concerned about alcohol problems and has literature specifically for LGBT individuals. Although open to all, AA meetings involve a random group of people and may reflect the perceptions and prejudices of those individuals and the local community and not be supportive of openly gay members (Kus, 1989). Many communities now have LGBT-specific AA, Narcotics Anonymous (NA), and Al-Anon meetings. Many LGBT people, however, mistakenly link AA and religion and resist attending since many religious institutions denounce or condemn homosexuality. For example, because of the moral condemnation of some religious bodies, references to a higher power or God in the 12-step model may, in fact, create fear of prejudice rather than assurance of support. While AA advises same-sex sponsors, recovering LGBT individuals require some flexibility, in that same-sex sponsorship may create problems. Many times AA respects this need. In locations where they are available, counselors should consider exposing their LGBT clients to LGBT-specific 12-step meetings so that any problems or issues relating to those meetings can be addressed while the clients are in treatment.

Some groups similar to AA have formed to meet the needs of LGBT people, such as Alcoholics Together. Many large cities sponsor

"roundups"—large, 3-day weekend gatherings focused on AA, NA, lectures, workshops, and alcohol and drug-free socializing. Some LGBT people entering recovery, however, may not have come out publicly or may not feel comfortable in such meetings, especially if a discussion of sexual orientation was not part of the early recovery process.

Twelve-step programs such as AA and NA recommend avoiding emotional stress and conflicts in the first 6 months of recovery. However, for LGBT persons, the risk of a relapse may be increased if they cannot begin to work through these issues. Discussions about sexual orientation and learning to live comfortably as an LGBT person are essential for recovery, even if these topics are emotionally stressful.

On the other hand, waiting 6 months to deal with this issue may be helpful. The client will have the increased confidence that 6 months of sobriety brings as well as a clear head. Just like many other people in recovery, LGBT individuals may find some of the suggestions and guidelines of AA, NA, and some treatment programs difficult to follow. Giving up or avoiding their old friends, especially fellow LGBT substance users, may be difficult when clients have few other contacts. Staying away from bars, parties, or circuit parties may be difficult if those are their only social outlets. The counselor may need to provide special help on how not to drink or use drugs in such settings or, better yet, help clients find social environments that support recovery. Clients will need to learn how to adjust to clean and sober socializing, without the use of alcohol or drugs to hide their social anxiety.

Many localities now have LGBT health, mental health, or community centers, almost all of them with a focus on recovery and substance abuse treatment. National organizations, such as the National Association of Lesbian and Gay Addiction Professionals, the Association of Gay and Lesbian Psychiatrists, the Gay and Lesbian Medical Association, the Association of Lesbian and Gay Psychologists, the National Association of Alcoholism and Drug Abuse Counselors' LGBT Special Interest Group, and National Gay Social Workers, may help with appropriate referrals.

Additional things the newly sober client should learn are how to have safer sex while clean and sober, how to deal with the damaging effects of substance abuse on employment and relationships, and the adjustment to recovery couples must make that will heal the client and avoid the negative impact of codependent relationships.

Case Example

Ruth is a 47-year-old African-American lesbian living in a large midwestern city. She is currently in an inpatient substance abuse treatment program that is gay sensitive. She has talked openly about being lesbian, and her partner of the past 25 years has been part of the treatment program.

Ruth was admitted for help with her crack cocaine use. She grew up in a very poor part of the city but had developed supports and strengths at her local Baptist church. Ruth and her mother went to regular services and many social functions, and she developed many friendships. She did well in school and liked sports. She was surprised one day in the ninth grade when she read a story about a lesbian teacher and felt a sudden awareness of sexual feelings for other women. She went home to talk about it with her mother, who said she should talk to the minister. When Ruth told him about her feelings, he became very upset, said she was an abomination before God. Although some clergy are LGBT supportive, this minister asked Ruth's mother to keep Ruth away from the church until she "recovered her senses." Ruth's mother agreed.

Very upset and confused, Ruth ran away from home. She became homeless and discovered that she could escape her feelings by using crack cocaine. To get money for food and drugs, she began to work as a streetwalker. At a special celebration for a homeless center a few years later, she met a city worker who happened to be black and lesbian. They formed an improbable relationship, and her partner brought Ruth off the streets and into a loving living arrangement. In the last 25 years, Ruth went back to school and worked as a substance abuse counselor. She has been clean and sober most of that time. She relapsed recently after her mother died and the old minister refused to let her attend the funeral in her old Baptist church.

Her lover was still supportive but was getting frustrated and angry. The lover had a history of severe depression and was treated with psychotherapy and medications; she again sought help from a therapist. That therapist convinced the lover to bring Ruth in for couples counseling. After being suspended from work for absenteeism, Ruth finally agreed. The therapist helped Ruth accept that she had relapsed and that she needed to get clean and sober. The couple's therapy work was suspended while Ruth entered an out-of-town inpatient treatment program. Ruth said she was too embarrassed to seek help locally since she might run into her fellow counselors and current or former clients.

Suggested Interventions

This case presents a unique situation but touches on several important themes: treatment level, location, and type; racism and homophobia; mental health or emotional stresses and relapse; and religion. A counselor working with Ruth will have many challenges.

- Relapse is possible at any time. LGBT people in long-term recovery may be very embarrassed about relapsing and use that as an excuse to avoid 12-step or other interventions. LGBT substance abuse counselors may feel that they have even fewer treatment options, especially if they wish to preserve a sense of personal confidentiality. In Ruth's case, the out-of-town location may not have been necessary from a clinical point of view (that is, the treatment at a local site may have been just as good as the site chosen), but the client accepted the intervention and referral. Since getting back on the path of recovery is so important, this concession made perfect sense.

- Relapse can be triggered by many things. Though nothing like a death or a reaction to prejudice causes the substance abuse, the emotional reaction to such events may be the trigger that brings on a relapse. Ruth will have to face several emotional challenges in her early recovery, and her substance abuse counselor will need to help her pace the rate at which she confronts the issues to help her remain clean and sober. The death of her mother, the homophobia of her church, her concern about the effect of her behavior on her lover, her return to work, and revisiting her own internalized homophobia all will be part of her long-term recovery.

- Religion and spirituality may play a very important part in recovery from substance abuse for many LGBT people. If the client's church is an issue, the counselor may need to help the client find an LGBT-accepting church or a different church branch. Some organized religious groups and churches have congregations for LGBT people. Most religious groups will have some LGBT-sensitive, if not even openly LGBT, clergy who may be very helpful. Counselors will need to know the difference between religion and spirituality and help the LGBT client understand that difference. Such a client may find spiritual comfort even if he or she cannot find religious comfort.

- Psychotherapy usually does not work for substance abusers who are actively using. In Ruth and her lover's case, couples therapy would probably not have been helpful. The therapist was very aware of the need to recognize this fact and used the couple's meetings to help the lover shape an intervention, which led to Ruth beginning treatment. After Ruth is clean and sober for several months, the couple could start therapy if it is still needed. Meanwhile, the lover can continue to seek the help she needs to manage her own depression.

- Ruth herself will also need to see how much of her life has been affected by racism and homophobia. If it has not been explored in past counseling, it will need to be looked at to help shore up her recovery. In the same way that not acknowledging the effects of homophobia may make relapse more likely, so, too, will not addressing the impacts of racism.

- Since the lover is so involved in Ruth's life and recovery, she should play a role in the early recovery process. Ruth's inpatient treatment counselor will need to include her just as she would the significant other of a non-LGBT person.

SECTION II:
CLINICIAN'S GUIDE

Chapter 5 The Coming Out Process for Lesbians and Gay Men

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What providers will learn from this chapter:

- The definition of the coming out process and what is known about it
- Potential interaction among substance abuse, recovery issues, and the coming out process
- Ways counselors can use their understanding of coming out to help lesbian and gay clients

Introduction

This chapter presents information on the coming out process so substance abuse treatment providers will understand what lesbian, gay, bisexual, and transgender (LGBT) clients may experience and how their support will help LGBT clients deal with this issue.

The term "coming out" refers to the experiences of some, but not all, gay men and lesbians as they work through and accept a stigmatized identity. The coming out process for many gay and lesbian people is a way of transforming a negative self-identity into a positive identity. This process is especially important to people who are trying to recover from substance abuse. For many people, feeling positive and hopeful about themselves is at the heart of recovering from addiction. It is noteworthy, however, that for many reasons not all gay men or lesbians come out. Many people who are attracted to, love, and/or are sexual with people of the same sex do not consider themselves gay or lesbian and do not go through any of the stages presented in this chapter.

What the Coming Out Process Means for Counselors

The coming out process is a very important one. Many recovering LGBT clients spend years working through issues related to coming out (both to themselves and to others) and working through their internalized homophobia to feel good about themselves.

If all goes well, they will eventually be able to say, "I am who I am, and I accept myself as myself." Because many recovery programs value authenticity and honesty, the process of coming out for many gay men and lesbians is crucial to becoming and staying sober.

Counselors who can accept and validate clients' feelings, attractions, experiences, and identities can play an important part in those clients' sobriety. Clients who drank and used drugs to medicate their negative feelings about being gay need to have those experiences understood. Others who used substances to accept their gay feelings and behaviors may need help in sobriety to work through those experiences again in a sober way. The coming out process does not happen according to a schedule. Some people may have come out during their teen years, and others may be working through the process during middle age or later.

No correct way exists to move through the coming out process. Some people may decide that they do not want to take on a gay or lesbian identity and may choose not to disclose their feelings and experiences to anyone. Counselors need to validate the needs of each client and find a way to understand their experiences.

A major issue for every client is how to become and stay healthy. To be most helpful, counselors need to assess at which stage of coming out the client is and understand the risks and needs of the client at that stage. For example, it is not advisable to refer a client in the first or second stages to gay or lesbian Alcoholics Anonymous (AA) meetings or to suggest that the client discuss his or her sexual identity in group therapy. The counselor may be the only person a fragile client can trust during the early stages. Or, if an LGBT client is in the fourth stage and distrusts straight people, attending gay or lesbian AA meetings or finding a gay or lesbian sponsor might be beneficial. In general, counselors who can view coming out as a lifelong process of growth can help their clients with recovery and self-acceptance.

Stage Models of Transforming an Identity

Stage models provide a useful description of the process by which some people come to call themselves gay or lesbian. The models also suggest a way of looking at how substance use and recovery interact with being gay or lesbian and with the ways people experience their sexual identities. Bisexual and transgender people may have some of the same issues and problems during recovery and learning to accept themselves. The available coming out models do not address the issues of transgender individuals, although some models discuss gender roles while addressing sexual orientation (DeCecco & Shively, 1985; Bockting & Coleman, 1993). Fox (1995) addresses the development of bisexual identity. In general, it is a false assumption that bisexual, transgender, gay, and lesbian processes are parallel, even when some similarities are noted.

Stage models are general guides to help counselors understand the coming out process; however, there are several points to remember. The models are not linear, and people do not necessarily move through them in order. One stage is not better than another, and people should not be seen as more advanced and mature if they are in a later stage.

William Cross (1971), an African-American psychologist, created one of the first models describing how a person with a stigmatized identity undergoes an identity transformation and then learns to manage and integrate this new identity. His stage model described the process by which a "Negro" recovered from the effects of discrimination by transforming internalized racist cultural values and attitudes and developed a positive identity. Similarly, Cass (1979) proposed a model for the process by

which gay men and lesbians transform their stigmatized identities from negative to positive.

A number of other models exist, usually with four or five stages and with some variations in focal point (Coleman, 1981/1982; Kus, 1985; Sophie, 1985/1986; Troiden, 1988; Woodman, 1989). For example, whereas Cass (1979) focused on ego functioning, Hanley-Hackenbruck's (1989) model examined superego functioning and the ways people changed their superegos from critical to ambivalent to accepting of themselves. McNally (1989) interviewed lesbian recovering alcoholics and proposed a model that described how lesbians transform their identities from active alcoholic to sober ones, how they came to feel positive about themselves as lesbians, and how their alcohol abuse and recovery interacted with the stages of developing a sexual identity. It is also noteworthy that these stage models resemble Prochaska, Norcross, and DiClemente's (1994) stages-of-change model, a model originally developed to determine treatment readiness.

Stage One: Identity Confusion

Most identity stage models suggest that the first stage involves some denial and confusion regarding one's feelings of attraction and sense of self. Cass' (1979) stage one is **Identity Confusion**, which occurs when people see their behavior as homosexual and face a crisis about who they are. Many people use alcohol and drugs to manage the painful feelings of this stage. They may drink or use drugs to cope with their anxiety and shame or to socialize or be sexual with a person of the same gender. They may use substances to help block out unwanted feelings of attraction toward people of the same sex or to keep from ascribing personal meaning to behaviors they consider unacceptable. Consider the examples of "Joe" and "Mary." For many years, Joe drank to drown out a sexual experience in high school in which he had sexual and loving feelings toward his best friend. He was terrified that he might be gay and did not want to bring shame to his religious family. Mary drank to cope with the confusion of being sexual with Sally, her roommate, and to avoid seeing herself as a lesbian.

Stage Two: Identity Comparison

In stage two, **Identity Comparison**, people begin entertaining the possibility that they may be gay or lesbian. In this stage, anxiety can be considerable, as people deal with their denial about their sexuality. People in this stage are often in emotional pain and are quite vulnerable. Substance abuse may be the primary way they have to deal with the pain associated with an experience that breaks through their denial and shatters their sense of heterosexual identity.

The examples of "Matt" and "Joan" are instructive. Matt always thought that he was heterosexual, but when he became emotionally and sexually involved with his college roommate, he began to question his identity and feelings. When his roommate broke off the relationship, Matt was devastated. He drank excessively to cope with his feelings about the breakup and his identity confusion. He went in and out of several detoxification and rehabilitation facilities during this stage of confusion, secretly struggling with inner turmoil and anguish. He finally received help when a counselor identified his conflict and helped him describe his feelings, offering him some hope of resolving his conflict if he stayed sober.

Joan was so frightened when she felt attracted to a lesbian she met at work that her drinking increased and her job was in jeopardy. When she entered treatment to save her job, Joan whispered to her counselor that she might be "one of them" but did not want to be and could not talk about it. Her counselor reassured Joan it was her choice whether to discuss it.

Stage Three: Identity Tolerance

In stage three, **Identity Tolerance**, people begin to have a greater level of commitment to a new identity ("I probably am gay/lesbian."). These feelings increase the sense of alienation and isolation. In response, people seek out gay and lesbian individuals and try to connect with the gay community and culture. If a lesbian or gay man is in treatment at this point, the counselor can help by suggesting attendance at gay- or lesbian-affiliated AA or Narcotics Anonymous (NA) meetings. If people remain open to this growth process, their self-image may change and they can say, "I am gay" or "I am lesbian"—an assertion that marks the beginning of the next stage.

Some people identify themselves as bisexual before they identify themselves as gay or lesbian. This stance may be easier because they believe others may be more accepting of them as bisexual than as gay or lesbian. Because the transition from identity tolerance to identity acceptance is a highly individual process, it is important that counselors not force clients into declaring they are gay or lesbian but respect and support individuals in their process. Although some individuals may see themselves as bisexual as part of their coming out process, other individuals are clearly bisexual and need to be accepted as such.

Stage Four: Identity Acceptance

The **Identity Acceptance** stage is characterized by increasing contacts with other gay and lesbian individuals. It also involves experiences that help "normalize" a gay or lesbian identity and way of life, and this stage can introduce new opportunities for drinking. Consider the experiences of "Veronica" and "John." Veronica told her counselor that when she began to come out, her drinking "just took off and went through the roof!" She spent much of her time in gay bars and drank heavily at every opportunity to socialize and be sexual.

John had been quite close to his family, but he believed family members would reject him if they found out he was gay. While he was enjoying his new gay and lesbian friends and his activities in the gay community, he used marijuana and drank heavily every day to medicate his anger and sadness about the loss of his family. Thus, as people increasingly become able to accept rather than tolerate their homosexual self-image, their substance abuse problems may, in some cases, become more severe.

People in the early stages often have fragile identities and find it difficult to cope with non-LGBT people who do not understand the need to be with people similar to them. They may disclose their identities to intolerant people in unsafe situations. For example, "Ed" felt so good about being gay and falling in love with "Jorge" when he got sober that he wanted to tell his boss and coworkers his happy news. His counselor was able to help him exercise some restraint. "Jan," for instance, was happy about coming out as a radical lesbian feminist separatist and claimed her identity with a great deal of enthusiasm. However, she refused to enter a rehabilitation facility that treated men and would go only to a women's program that she felt would be sensitive to her needs as a lesbian. There her counselor could respect her political or emotional position while helping her recover.

Stage Five: Identity Pride

If people move to **Identity Pride**, stage five in Cass' model, they do so with an awareness of the difference between their acceptance of their own homosexuality and society's rejection of it. There is a tendency to get angry, to split the world into gay and straight, and to respond to heterosexism by rejecting the dominant heterosexist culture. People may become active in the lesbian/gay community and spend the majority of their time with others who share their feelings and perspectives.

"Collette's" drinking and political activity as a feminist have been deeply and passionately intertwined for many years. She angrily tells her counselor that he does not understand anything—no man can possibly understand her; no heterosexual can, either. She tells him that everyone she knows drinks the same way she does and that she cannot imagine how she can carry on her work as an activist without drinking. If she stops drinking, she will lose everything and everyone who means anything to her. Her counselor listens with concern and tries to empathize with her terror and rage in the face of what she believes is the loss of her whole way of life.

Stage Six: Identity Synthesis

In stage six, **Identity Synthesis**, an awareness develops that the dichotomy of "them and us" is not valid. Anger decreases, pride becomes less aggressive, and the gay or lesbian identity is more integrated with other aspects of the individual. It may be difficult for people to attain this level of identity integration and synthesis if they have been drinking heavily and using drugs for a considerable length of time.

Counselors should explore the meaning of clients' stating they have been out for 30 years or they have been gay since the age of 7. The length of time they consider themselves gay or lesbian does not necessarily predict whether people have worked through the process of claiming a positive gay or lesbian identity or of feeling good about themselves as gay men or lesbians, especially when they have spent many years abusing alcohol or drugs. Clients' meaning of the word "out" may be highly individual. A client who describes herself as out for 2 years may mean that 2 years ago her mother discovered that she was involved with a woman.

Recovery Issues for Lesbians and Gay Men

People who have been using alcohol and drugs for many years may have anxiety and confusion about who they are and how to make sense of the experiences and feelings they encountered during their active addictions. Counselors need to help people in recovery begin to address the task of struggling with the question, "Who am I, now that I'm clean and sober?" People in recovery need help sorting out various aspects of themselves, such as, "What does it mean to be a man? A woman? Gay? Lesbian? Straight?"

If we look at gender identity and sexual identity on a continuum with male and female being the endpoints of gender and gay and straight being the endpoints of sexual identity, we can see that society forces people to one or the other of the endpoints—even though this may not actually characterize their feelings or experiences. An important part of treatment may be helping people tolerate ambiguity and diversity. Counselors may be the first people to tell substance abusers that whoever they are is okay, that they do not have to declare themselves gay or straight or bisexual, and that an important part of recovery may be to spend time exploring who they are. Clients may need to explore the meanings of their various feelings and experiences. At the same time, other individuals may arrive in treatment stating they are "okay about being gay" but in reality are still struggling with self-acceptance. Counselors can help these individuals to identify the pain masked by their addiction and to accept who they are and the identity they may wish to embrace. In addition, some "out" clients may find that their gay or lesbian friends may not understand or may resent their recovery efforts. Counselors can alert clients to this issue and can assist them in making choices about how and with whom they share their recovery.

Case Example

Lee is a 43-year-old Asian-American married woman who has been relapsing for over a year and is currently in an aftercare relapse group. She is quiet and shy, never offering to say much in the group about herself, but she is quite supportive and helpful to others when they discuss their problems. However, when people in the group ask her about problems in her life with sobriety, her husband and children, or other relationships, she looks at the floor and seems quite uncomfortable. She responds in short, whispered phrases and then falls silent. Lee's counselor notices that, after a woman in the group comes out as a lesbian, Lee becomes even more anxious and agitated. She asks the lesbian client why she has to come out and flaunt her sexuality.

During an individual session with Lee, the counselor asks her if something is going on in her life that makes her feel uncomfortable with the lesbian client. Lee says no. The counselor asks whether Lee has ever been approached by a lesbian. Lee says no. The counselor asks whether Lee has ever had any lesbian feelings herself. Lee says no. The counselor feels frustrated, but tries again. She asks whether anything of a sexual nature happened when Lee was drinking that upset her in any way. Lee is silent, looking at the floor. She begins to cry and tells the counselor that she can't talk about anything. She says she is too afraid. She doesn't want to lose her family. She can't bring shame on herself and her whole family. The counselor reassures Lee that whatever they talk about is confidential and will not go any farther.

Through much crying and sobbing, Lee tells the counselor that she is terrified that she might be a lesbian. She says that she sometimes has dreams and fantasies about being sexual with women, and once when she was drinking, a woman flirted with her at a party. She thinks they might have been sexual, but she's not sure; she was having blackouts at the time. She doesn't know what to do. She doesn't feel attracted to her husband and thinks this must mean she's a lesbian, but she doesn't want to be a lesbian. Lee cries and expresses deep despair and shame, but relief, too, at finally telling someone what she thought she could never disclose. The counselor, too, knows that Lee finally has a chance to stop relapsing and to begin her sobriety.

Suggested Interventions

What stage a person is in should determine which interventions are appropriate for and sensitive to the patient's needs. In the example above, the counselor created a safe atmosphere for Lee by asking questions in private rather than in the group and by asking them in a way that reassured Lee, while telling her that she could talk about herself. The counselor might follow up on Lee's disclosure with some private sessions and refer her to a knowledgeable therapist to help her with her feelings and concerns about her sexual orientation. Because clients in stages one and two usually are frightened, confused, and vulnerable, they need help and support from counselors to talk about their feelings and experiences. Because of their shame and anxiety, clients are vulnerable to relapse, and counselors need to help them by talking freely about their sexual identity, raising the issues, and discussing them openly.

Guided by the stage model, counselors need to intervene in ways that fit the client's particular needs, desires, culture, experiences, and feelings. For example, if a person in stage four wants to come out to his parents, boss, and family, a counselor could help the client explore the possible positive and negative consequences of such disclosures. Clients in this stage may not know where to socialize with other sober gay or lesbian people. Referral to sober resources is important. If a client comes out to himself or herself while in treatment and begins to move into stage three, a counselor might need to help the client with family or job issues, religious guilt, and other problems that could threaten the client's sobriety. Making a referral to gay and lesbian AA/NA or other support group meetings at this time and to gay or lesbian therapists is quite important to clients to help them maintain their sobriety and cope with all the complex and difficult issues related to being gay and lesbian and recovering from substance abuse.

Chapter 6 Families of Origin and Families of Choice

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What providers will learn from this chapter:

- What a counselor needs to know about relationships and families when counseling LGBT clients
- The difference between families of origin and families of choice
- How a counselor can identify unresolved issues with a client's family of origin that could trigger a relapse
- How a counselor can be sensitive to an LGBT client's family of choice in treatment

Introduction

This chapter addresses the family dynamics that are important in working with lesbian, gay, bisexual, and transgender (LGBT) individuals and how counselors can put their understanding of these dynamics to work in counseling LGBT clients and their families.

Like nongay clients, LGBT individuals seeking recovery are involved in multidimensional situations and come from diverse family backgrounds. Family, relationships, friends, social interactions, work issues, self-esteem, increased understanding of self-identity, and community support all are part of the focus of the treatment and recovery process. During the course of treatment, it is important to identify stressors that can trigger a return to substance abuse and addiction. LGBT individuals, in particular, need an intake assessment that is comprehensive, inclusive, and culturally sensitive.

Family of Origin

Family of origin refers to the birth or biological family or any family system instrumental or significant in a client's early development. Taking a family history and reviewing the dynamics of the family of origin should be part of a thorough biopsychosocial assessment. Counselors should exercise great care in asking sensitive questions, particularly about members of the family of origin. The client's cultural norms will be particularly important during this

questioning and should be respected for an assessment to be effective.

LGBT clients often will have unresolved issues about their family of origin, particularly regarding sexual orientation or gender identity. As they do with all clients, counselors need to review the client's role in his or her family of origin, because unresolved issues with the family of origin can act as emotional triggers to a relapse.

The following questions can help the counselor gather relevant information and assess what unresolved issues might interfere with clients' ability to maintain sobriety.

- What were the rules of the family system?
- Was there a history of physical, emotional, spiritual, or sexual trauma?
- Were all family members expected to behave or evolve in a certain way?
- What were the family's expectations with regard to careers, relationships, appearance, status, or environment?
- In general, was sex ever discussed?

Concerning sexual orientation and gender issues, counselors can begin by reviewing with clients how differences were perceived in the family. The following questions would be appropriate to explore:

- Was anyone else in the family acknowledged to be or suspected of being a lesbian, gay, bisexual, or transgender individual?
- How did the family respond to other individuals coming out or being identified as LGBT individuals?
- Is the client out to his or her family?
- If the client is out, what type of response did he or she receive?

The family of origin's response to one's disclosure of an LGBT identity can have a long-lasting and—if it is negative and unaccepting—often devastating effect on an individual. Responses can range from abusive, rejecting, or avoiding to tolerant, supportive, or inclusive. LGBT individuals need to process these messages, roles, rules, images, and stereotypes about sexuality in addition to the messages they receive from society in general.

What makes the LGBT experience different from the experience of other cultural minorities is that LGBT individuals experience prejudice and, most frequently, a disconnection from other members of their minority group. Even in a multicultural family, an adolescent is able to look beyond his or her immediate family to the cultural community and find someone to identify with. This typically is not true for LGBT individuals, who usually grow up without information on or contact with other LGBT individuals.

In his book, *Healing the Shame That Binds You*, John Bradshaw, Ph.D. (1988), refers to the "toxic shame" that is created in childhood and stays until the individual learns to purge it. Similar processes have been explored by authors who write about recovery and families, for example, Janet Woititz, *Adult Children of Alcoholics* (1990); Earnie Larsen, *Stage II Recovery* (1991); Ann Wilson Schaef, *When Society Becomes an Addict* (1988); and Michael Picucci, *The Journey Toward Complete Recovery* (1998), as well as numerous others who acknowledge the importance of resolving these conflicts from our childhood and our family of origin.

Family of Choice and Relationships

Providing support for LGBT clients and their families of choice is a crucial element of substance abuse treatment, just as it is for all clients. A family of choice is made up of individuals who are significant to the client, and it needs to be included in any assessment. It includes individuals who have died or are no longer an immediate part of clients' lives, sometimes because of addiction, HIV/AIDS, or other life events. A family of choice does not necessarily exclude blood relatives. By definition, it includes those who, by their support, nurturing, and understanding, have earned a significant place in the LGBT individual's life.

Substance abuse counselors and treatment centers need to create a safe place for healing. This safety needs to include respect, understanding, and support for the life partners and significant others of their LGBT clients. It cannot be overstated that these individuals must be included in services similar to those offered to the spouses of heterosexual clients.

In order to work effectively with LGBT clients, substance abuse treatment counselors need to have some understanding of the dynamics of LGBT interpersonal relationships. This includes awareness of the internal and external problems of same-sex couples and the diversity and variety of relationships in the LGBT community. As noted previously, not all individuals in relationships with people of the same sex, or engaging in same-sex behavior, consider themselves lesbian or gay. The counselor needs to be sensitive to the individual's self-identification. Counselors also need to be aware of the lack of universal terminology with regard to significant others in the LGBT community. The terms "lover" or "significant other" can mean different things depending on cultural or generational differences. Interpersonal relationships span a spectrum of emotional significance that is as diverse as LGBT communities. Although many individuals seek out a life partner, others are single or may find themselves in nontraditional arrangements. Counselors need to be aware of their own biases when working with individuals who—as a result of their affections—find themselves outside the cultural norm of a heterosexual, monogamous, and legally sanctioned marriage.

Lesbian, gay, and transgender (LGT) individuals with a previous history of opposite-sex relationships add a new level of complexity to their relationships that approaches that of bisexual individuals. Like their heterosexual counterparts, some LGT individuals maintain close contact with their opposite-sex partners. Others consider such relationships to be part of a previous "life" before coming out.

One particular stressor for LGBT individuals in interpersonal relationships is the level of comfort with one's sexual orientation. A couple could, for instance, consist of one person who is closeted while the other is out. When couples are at different stages of self-acceptance regarding sexual orientation, it can be a source of great tension within the unit.

Parenting Issues

A common misconception is that LGBT individuals are not partnered and do not have children. The reality is that many LGBT individuals are coupled, have children, and exercise the same responsible parenting as their heterosexual counterparts. Many LGBT individuals have children from previous heterosexual marriages. Moreover, as more LGBT couples adopt, become foster parents, or use alternative routes of insemination to become pregnant, substance abuse treatment counselors can expect to be working with more LGBT clients who are parents, either as part of a couple or as single parents.

When children are added to a family system, parent-child relationships, the role of

stepparents or members of the blended family, and the birth parent (if any) must be factored into the family dynamic. Counselors may have a concern that children growing up in LGBT families are likely to become LGBT individuals, but this concern is unfounded. As we have seen in chapter 1, the etiology of sexual orientation is so complex that the sexual orientation of parents or family members is not an issue.

Individuals in treatment need to be concerned about losing custody of their children. See chapter 3 for a discussion of this issue and other legal issues of particular concern to LGBT parents.

Chapter 7 Clinical Issues With Lesbians

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What providers will learn from this chapter:

- The range of diversity among women who see themselves as lesbians or whose sexual/emotional/affectional feelings and behavior are primarily directed toward women
- The myths and stereotypes about lesbians that need to be explored and corrected
- The clinical issues and concerns specific to lesbian clients
- How counselors need to respond to issues specific to lesbians who are substance abusers

Introduction

Perhaps the most important thing a counselor needs to bear in mind when working with lesbian clients is that there is no **one** lesbian client—that there is tremendous diversity among lesbians. As women, lesbians share the diversity inherent in womanhood; they also share the experience of dealing with sexism. The range of their experiences, perspectives, life situations, and statuses can hardly be overstated. Lesbians are from all races and ethnic groups, all socioeconomic levels and ages, all areas of the country and indeed of the world. Some lesbians are sexual with men at times, yet see and identify themselves as lesbians. Some women have same-sex relationships, but do not see themselves as lesbians. There are also women who choose to self-identify as lesbians on the basis of their emotional attraction to other women and in spite of being sexually attracted to men.

While some lesbians have children or want to have them, others do not. Some women have known they were lesbians since the age of 5 or 6 years (but were without the vocabulary to describe it at the time). Others become aware of their attractions to other women only in later life, often after having been in a heterosexual marriage for a number of years. Some lesbians are very comfortable with and public about their lesbian identity. Others have great difficulty taking on a lesbian identity and may keep it secret and hidden, whether from shame (internalized homophobia) or from a need to

protect their jobs or maintain relationships. Some lesbians may look and act "masculine," whereas others may look and act "feminine." Many lesbians are not at all distinguishable from the general population of women.

Lesbians exhibit great diversity in their drinking or drug-taking behavior as well. There is no single pattern of such behavior among lesbians who are substance abusers. In this sense, again, they also may be indistinguishable from the general population of women.

Destructive Myths and Stereotypes

Counselors need to be aware of the numerous myths and stereotypes that our society tolerates and sometimes promotes even though they are inaccurate and can be destructive. Such awareness enables counselors to check out their own belief systems and help work with their lesbian clients on issuos specific to their sexual orientation.

One set of myths is that lesbians hate men, that they are afraid of men, or that they want to be men. The truth of the matter is that a small number of lesbians may hate men, but so do some heterosexual women. A small number may be afraid of men (as are some heterosexual women) and often for good reasons (e.g., rape, sexual abuse, physical violence, sexism). It can certainly be said that many lesbians **and** many heterosexual women want the same power that men have by virtue of having been born male. Most lesbians do not hate men; they are not afraid of men, nor do they want to be men. Likewise, the idea that all lesbians are masculine or "butch" is not true.

Another myth is that lesbians do not have stable relationships and are either particularly loath or anxious to form committed relationships. A number of younger lesbians engage in serial dating and are not monogamous. Like their straight counterparts, some might be judged promiscuous, but it is more accurate to see them as following the mores of their peers and their generation's culture. Conversely, a myth exists that lesbians form committed relationships instantly and stay together as long as they possibly can. Again like heterosexual women, some lesbians may form lasting committed relationships too soon for their own good, whereas others may not.

A pervasive myth to consider is that life as a lesbian is only—or predominantly—about being sexual or that a lesbian identity is purely a sexual identity. Although being lesbian most certainly is about being sexually attracted to other women, many lesbians also talk about the power and importance of their emotional and affectional feelings and attractions for other women.

Common myths also suggest that there is a sexual cause for lesbianism, such as having had bad sexual relationships with men, or having been sexually abused by men, or not being sufficiently sexually attractive to men.

An offshoot myth is that lesbians are sexual predators, that they are always looking to seduce one another and heterosexual women. This myth strains credulity since women are not known to be sexual predators and indeed receive strong messages from our society discouraging sexual aggression.

One other set of myths that needs to be challenged relates to the idea that sexual orientation is a matter of choice. These myths merit some discussion here, although a fuller treatment is provided in chapter 1. It is true that lesbians can change their sexual **behavior**. Many women who eventually self-identify as lesbians live for years behaving as heterosexuals. They may take husbands and have and raise children. Despite appearances, however, they cannot always be said to have changed their sexual orientation. Two related myths are (1) that lesbians would prefer to be heterosexual and would, in fact, choose to change their

sexual orientation if they could, and (2) that sexual orientation is caused by a hormonal imbalance and could be changed by taking the right hormones.

What is important about the myths are the underlying assumptions—that heterosexuality is superior to homosexuality: more moral, healthier, and more natural. These beliefs can make life in recovery harder to negotiate.

Clinical Issues With Substance-Abusing Lesbians

Too little is written on the incidence, prevalence, and patterns of substance use among lesbians. Many formal studies have generalized from gay males to lesbians, whereas others have used unreliable sampling methods. In the literature that is available, certain risk factors are noted repeatedly, such as:

- The reliance of many lesbians upon women's bars for socializing and peer support
- The interaction of sexism, stress, and substance use
- Issues related to coming out such as alienation from loved ones upon revealing one's lesbianism, the emotional dissonance of "passing" as heterosexual, and the use of substances to reduce the anxiety of these conflicts
- The interaction of trauma (discriminatory experiences, physical or sexual assault because of one's lesbianism) and substance use.

The traumas that lesbians may have suffered need to be recognized and understood as integral parts of their behavior, outlook, and emotional makeup. For example, the research findings of the National Lesbian Health Care Survey (Bradford, Ryan & Rothblum, 1994) reported that 21 percent of lesbians had been sexually abused as children and 15 percent as adults. (However, it is a myth that being sexually abused makes a woman a lesbian. That is false, even though some lesbians believe the myth.) For every lesbian client, the trauma of alcohol and drug abuse is added to the negative effects of homophobia and heterosexism. Finally, there may be other traumas, such as being African American or Latina in a prejudiced society. Attention to trauma issues may, therefore, be a key part of the overall recovery process of the substance-abusing lesbian.

In their 1997 review, Hughes and Wilsnack note some general patterns in lesbians' use of alcohol, including:

- Fewer lesbians than heterosexual women abstain from alcohol.
- Rates of reported alcohol problems are higher for lesbians than for heterosexual women.
- Drinking, heavy drinking, and problem drinking among lesbians show less decline with age than among heterosexual women.

Along with addressing the above concerns, counselors will find lesbian clients with a variety of issues as women and as homosexual persons. The roles partners and children play in the clients' use of alcohol and drugs and recovery are particularly important (see chapters 2 and 6), as are confidentiality and legal concerns (see chapter 3).

Counselors' Responsibilities

Because myths and stereotypes pervade our culture and influence our thinking and our behaviors, it is important for counselors to be aware of them and to help their lesbian clients not be further injured by them. This means counselors need to assess their beliefs in the myths so they do not impose them on their clients. Counselors need to be able to help

their lesbian clients deal with the effects of homophobia and heterosexism as they affect their clients' recovery. All people struggling to recover from alcoholism or drug addiction are vulnerable and easily hurt and can relapse when wounded or unsupported. Negative experiences can undermine or destroy the strength necessary to recover. An informed and sensitive counselor can make an enormous difference in a lesbian client's treatment and recovery.

Case Examples

Example #1: Rita, 52, a very attractive woman dressed in high heels and a form-fitting suit, is wearing tasteful, but dramatic, makeup. She looks like anything but an alcoholic. She is from the Dominican Republic and separated from her husband; she has two children, but is currently living alone. She is seeking treatment for "problems I'm having because of my drinking." She will lose her 7-year position in her company if she doesn't stop drinking, she is estranged from her family, and she has lost all her friends because of her drinking. Rita has tried Alcoholics Anonymous (AA) but is having great difficulty finding a sponsor ("Nobody is very warm or accepting"); she is also having trouble relating to other women in the program ("They're not very friendly. Maybe because I'm Latina."). When asked about her relationships with others, she looks embarrassed and mumbles something noncommittal. When the counselor directly asks, "Have you been in any long-term relationship with anyone in the past 10 years?" Rita stammers out that she had lived with a friend for 5 years. The counselor then asks if Rita can say more about the nature of the relationship, the quality of it, and the reasons for its ending. Rita answers in vague terms that she and her friend argued about how much Rita drank and that the friend finally left. As Rita continues her description, her vagueness suggests that the difficulty she is having talking about it might stem from a lesbian relationship (or her fear that it might have been one). The counselor must now decide whether to ask for more information.

Acting on the basic premise that Rita's secretiveness indicates a high level of anxiety about this subject and that her anxiety probably makes her distance herself from others for fear of being found out, the counselor presses on. How? Not by using the term "lesbian" or by going directly for this particular topic. Instead, the counselor asks such questions as, "Were you close to one another? Was your friend emotionally supportive of you?" And the counselor can empathize, saying such things as, "The breakup must have been very painful for you. When he or she left, how did you cope with the loss?" Now the counselor has introduced the possibility that the friend is a woman and offers Rita the opportunity to edge a little closer to being able to talk about the fact that this close relationship was with a woman. It is important to note here that the counselor is not using any label (such as "lesbian") and is only indirectly exploring the quality and nature of the relationship. If and when Rita can begin to talk in more detail about this relationship, the counselor needs to continue the exploration in this restrained manner because the topic is so frightening to Rita. Such restraint on the counselor's part is crucial because Rita has been able to pass for straight, something that has been of great importance to her because the Latino culture and her family are extremely homophobic. Restraint is also crucial because it creates the safety essential to engendering the patient's willingness to participate in her treatment and recovery.

Example #2: Andrea, 23, has been drinking alcohol since she was 12. She also became addicted to her mother's Valium and uses it to "smooth out" her hangovers and to come down from her occasional cocaine highs. Andrea has known since she was about 9 that she is attracted to girls and has been sexually active since the age of 14. She is totally out as a lesbian and says she has no problems about her sexual identity. But she is troubled by her inability to sustain any relationship for longer than a few months. She also says that since she's achieved sobriety, she doesn't know how to meet women who want to date her. She has become shy and uncertain—she says, "retarded." The counselor needs to help Andrea assess where she is in the development of a sober and clean identity and how that relates to her sexual orientation. She has not been able during her formative years to learn the necessary developmental lessons of adolescence. Furthermore, she tended to act out her feelings when drunk or drugged, including a lot of sexual feelings. She never learned how to date or communicate or relate emotionally to others. The counselor needs to point out to Andrea that she will probably need to go back and come out again in some form, now that she's clean and sober, and that she will need to learn the tasks of adolescence that she missed learning.

Suggested Interventions

Although the responsibilities involved in counseling substance-abusing lesbians may seem daunting, there is no denying the importance and influence of the caring counselor. Counselors who don't know a lot about lesbians can still offer much of value to their clients if they start with what they know about women and take the time and make the effort to understand the special problems of lesbians.

Some suggestions for treatment are as follows:

- Empower the client—this should be the primary goal, no matter how it is reached.
- Honor diversity.
- Use nonjudgmental language.
- Avoid labeling.
- Do not confront, but support and explore.
- Respect the client's position, whatever that may be ("I'm not a lesbian"; "I'm confused"; "I'm a lesbian and proud of it!").
- Respect some lesbians' unwillingness to attend AA or Narcotics Anonymous because they consider these programs male institutions with no room for them as women, and especially as lesbians, or because of the emphasis on powerlessness, which they feel emphasizes their status as victims.

Chapter 8 Clinical Issues With Gay Male Clients

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What providers will learn from this chapter:

- The social, cultural, psychological, and developmental issues and treatment considerations specific to gay men
- Some of the societal, cultural, and emotional factors and expectations with which gay males must contend

Introduction

Many factors may contribute to the prominent role of substance use and abuse in gay men. At one point, American psychoanalysts even postulated that homosexuality itself caused alcoholism. We know now, of course, that homosexuality, repressed or not, does not "cause" alcoholism, because alcoholism and substance abuse are the result of the complex interactions of genetic, biological, familial, and other psychosocial factors.

However, the psychological effects of heterosexism, antigay bias, and internalized homophobia may make gay men more prone to using alcohol and other substances, and that use, in turn, may lead to substance abuse or dependency and may trigger the genetic expression of alcoholism and drug abuse. Higher rates of alcoholism have been documented in societies or cultures in turmoil or undergoing social change—a description that can be said to apply in the case of lesbian, gay, bisexual, and transgender (LGBT) individuals (Cassel, 1976). For most of the 20th century, societal pressures forced most gay people to remain "in the closet," hiding their sexual orientation or not acting on their feelings. Legal prohibitions against homosexual behavior, overt discrimination, and the failure of society to accept or even acknowledge gay people have limited the types of social outlets available to gay men to bars, private homes, or clubs where alcohol and drugs often played a prominent role. The role models for many young gay people just coming

out are often gay people using alcohol and drugs at bars or parties.

Some gay men, in fact, cannot imagine socializing without alcohol or other mood-altering substances. Brought up in a society that says they should not act on their sexual feelings, gay men are very likely to internalize this homophobia. Often their first homosexual sexual experience was while drinking or being drunk to overcome fear, denial, anxiety, or even revulsion about gay sex. For many gay men, this linking of substance use and sexual expression persists and may become part of the coming out and social and personal identity development processes. Even after coming out, many gay men will use mood-altering substances to temporarily relieve persistent self-loathing, which is then reinforced in the drug withdrawal period.

Given the lack of widespread acceptance of homosexuality and bisexuality in our society at this time, the stages of developing a gay identity may be intimately involved with substance use. Swiss psychoanalyst Alice Miller (1981) sheds light on the link between the psychodynamic forces in developing a gay identity and the use of substances in her work on the emotional lives of children who are talented or otherwise different. Her description of how parents influence the emotional development of these children has strong parallels with the development of a gay identity. Parental reactions shape and validate expressions of children's needs and longings. Parents reward what is familiar and acceptable to them and discourage or deemphasize behavior or needs they do not value or understand. To get rewards, children eventually learn to behave the way parents expect and to hide or deny the longings or needs that are not rewarded.

Many gay men fit Miller's description of being aware of being different early in life. They recognize that their loving and sexual needs and longings make them different from others around them. Some male children who will grow up to be gay may desire a closer, more intimate relationship with their father, but this desire often is not encouraged or even understood. The "prehomosexual" child learns to hide such needs and longings, creating a "false self." Real needs and desires often are repressed or rejected as wrong, bad, or sinful. Dissociation and denial become major defenses to cope with this conflict.

The psychology of being different, and of learning to live in a society that does not accept difference readily, shapes sexual identity development as a boy emerges from childhood and the latency period. Accustomed to the rewards of the false self, the child suppresses his more natural feelings. He usually has no clear role models to show him how to be gay.

In latency, boys who will become gay, especially boys who may be effeminate, may fear other children and become more isolated. In adolescence, gay sexual feelings can emerge with great urgency but with little or no permission for expression. Conformity is certainly encouraged, which may support further denial and suppression of gay feelings. Adolescents often reject and isolate those who are "different," so the gay adolescent further develops a disconnection between his feelings and his external behavior.

These same factors may also help explain the many problems facing gay youth—such as depression, suicidal thoughts (or attempts), and running away from home, as well as drug use—even if they have accepted their sexual orientation (Savin-Williams, 1994). Gay youth are subject to sexual abuse and violence and sometimes are introduced to sex via hustling or prostitution. They may be otherwise "used" or exploited sexually by others. The extreme difficulty many gay men have in coming out and integrating sexuality and personal identity makes sense from this perspective.

Substance use serves as an easy relief, can provide acceptance, and, most important, simulates the comforting dissociation or disconnection developed in childhood where feelings become separated from behavior. Alcohol and drugs cause a dissociation of feelings, anxiety, and behavior and may, in a sense, mimic the emotional state many gay men develop in childhood to survive. The "symptom-relieving" aspects help fight the effects of homophobia, allow "forbidden" behavior, provide social comfort in bars (or other unfamiliar social settings), and alleviate somewhat the familiar experiences of disconnection and isolation.

The easy availability of alcohol and drugs at gay bars or parties and the limited social options other than at bars and parties encourage the use of substances early in the coming out and gay socialization process. For gay men especially, sex and intimacy are often split. Substance use allows them to act on feelings long suppressed or denied but also adds a new disconnection and makes it harder to integrate intimacy and love. As some longings and needs find easy relief with sex and/or substance use, the much more challenging needs for love and intimacy may be ignored.

Substances help many gay men brace themselves for the rejection that they expect from others. They allow for denial and even "blackouts" about sexual behavior, including risky sexual behavior. They certainly can make living in the closet with its built-in need for denial and dissociation possible or even easier (the "I-was-so-drunk-I-didn't-know-what-I- did-last-night" scenario often used in high school and college).

The state that accompanies internalized homophobia and the one that occurs with substance abuse are very similar—the "dual oppression" of homophobia and abuse described by Finnegan and McNally (1987). The following traits are seen in both: denial; fear, anxiety, and paranoia; anger and rage; guilt; self-pity; depression, with helplessness, hopelessness, and powerlessness; self-deception and development of a false self; passivity and the feeling of being a victim; inferiority and low self-esteem; self-loathing; isolation, alienation, and feeling alone, misunderstood, or unique; and fragmentation and confusion. These close similarities make it very difficult for gay men who cannot accept their sexual orientation to recognize or successfully treat their substance abuse. Providers need to know that self-acceptance of one's sexual orientation may be crucial to recovery from substance abuse.

Being Male and Being Gay

Cultural expectations about what it means to be male, regardless of one's sexual orientation, add social and personal pressures. These cultural expectations—basically gender role expectations—vary by culture and ethnicity and can present quite different issues, for example, for gay men of color than for Caucasian gay men.

In general, however, the stereotypical male in America can be described as powerful, masculine, independent, emotionally reserved, and career motivated, rather than relationship motivated. Boys and men who do not seem to fit this stereotype—or who do not wish to act like this stereotype—may have trouble fitting in or being comfortable with themselves.

Part of societal heterosexism is confusion about what homosexuality is and what gay men are. Since most heterosexuals cannot imagine what it is like to be attracted to someone of the same sex or to be gay, they often mistakenly assume that a gay man is in some way like a woman. If a man wants to be with another man emotionally or sexually, they think, then gay men see themselves as like women. Cultures, especially Latin-based cultures, stigmatize any man who is like a woman. Some have speculated that this may be one

basis for antigay bias in America and a major factor in homophobia.

Gay men are not like women even though they are attracted to other men. Certainly men may be "effeminate"—that is, having some traits that are in general culturally attributed to women. Yet effeminacy has nothing to do with sexual orientation. Many effeminate men are heterosexual. Unless a gay man is also transgender, he does not think he is a woman or wish to be a woman.

Many gay men do, however, grow up differently from their heterosexual peers, and a good percentage of gay boys and men have traits and behaviors that are more commonly associated with girls or women. Examples of this include avoiding rough and tumble play and being less aggressive and less interested in sports than sterotypical heterosexual males. These traits do not cause homosexuality, but they may lead to a child being stigmatized. Many gay men report being made fun of in school, feeling isolated, and avoiding contact with the more "macho" types of boys—which, of course, adds to the stress of being different.

The alleged link between being gay and being effeminate or weak sometimes is believed even by gay men and makes them more ashamed of their gay feelings than they might be otherwise. Gay men who are more passive or who enjoy being the "passive" or receiving sex partner may feel deep shame and embarrassment about that behavior and desire, and that shame may contribute to their using alcohol and drugs to try to cope.

Some gay men may feel pressure—even or especially by other gay men—to be more "butch," masculine behaving, or macho than they feel comfortable with. This conflict may lead to acting more reserved or aloof in general, making it hard for them to relax. This pressure to be "aggressive" may also lead to alcohol and drug use, especially to drugs that make one feel more sexual or enhance sexual performance, such as amphetamines or amyl nitrate. This desire to be ultramasculine also contributes to the focus on looks and body image for many gay men, including working out at the gym and the use and abuse of steroids.

Gay Male Social Life

Gay men are an extremely diverse group, and generalizations, even about large subsets of gay men, tend to be more harmful than accurate. A few examples illustrate the point. Life for a gay man in a small midwestern town bears little resemblance to that of a gay man living in Los Angeles or rural Texas. A Latino gay may have a social environment quite different from that of a Caucasian gay man or an African-American gay man, even in the same city. A single, 18-year-old gay man lives a life quite different from that of a 65-year-old gay man in a committed relationship. Gay youth who have run away from home may find little to recognize in the life of a gay university professor living in a well-furnished apartment. Such diversity cannot easily be squeezed into neat stereotypes. In attempting to capsulize and target "gay demographics," media concerns and advertising agencies have taken on a daunting challenge.

The popular media portrays gay men in various stereotypes. A gay man is young, beautiful, and materialistic and focused on sex and partying. A gay man is into leather. A gay man dresses in drag (as a woman) and is extremely effeminate. Although some gay men may fit each of these stereotypes, the majority resists acting in ways that can be neatly summarized, or indeed fit any stereotype.

Young gay men just coming out, however, with limited role models or none at all, may believe these are indeed the ways to act if one is a gay man. If they do not comply with the stereotypes they see, they may feel they do not fit in. Gay

men of all ages may feel pressure to somehow be like the image of the gay man they see in the popular gay press or the general media—to be young, thin, well-built, usually Caucasian, and sexually focused—and feel that there is "ageism," "lookism," and even racism in the "gay community." Although these "isms" may exist in certain individuals, they certainly cannot be attributed to all gay men.

Gay men of color sometimes describe feeling invisible in settings where most of the other gay men are Caucasian, but this experience varies by city and region of the country. Besides the general antigay bias in our society, gay men of color may also face racism—from heterosexuals as well as other gay people. In addition, they may have specific cultural or ethnic issues about homosexuality or ways of having sex with which to contend (as may many Caucasian gay men). For example, many cultures do not condemn sex between men but at the same time do not acknowledge or discuss it, especially if the man is married to a woman or considers himself straight (or bisexual).

In spite of growing awareness and acceptance of gay people, social outlets for gay men still tend to be limited in both scope and location. The "gay ghetto," the section of town where gay people feel comfortable being and getting together, usually is identified by the presence of gay bars. The number of gay coffee shops, bookstores, and activities that do not involve alcohol and drugs is increasing, but gay bars and parties that focus on alcohol and drug use are by far the best advertised and most identifiable elements of gay social life.

An activity that seems unique to gay people—mostly men, though some lesbians take part—is the "circuit party." These parties are weekend-long gatherings that focus on dancing, sexual activity, and alcohol and drug use. Attended primarily by gay men in their early twenties to late forties, these parties are held all across the country (and indeed, around the world), forming a "circuit" of connected activities frequented by many of the same people who travel from event to event. The parties encourage drug use—to enhance the dancing (like at a "rave") and sexual activity. The "designer" drugs—ecstasy, gamma hydroxybuturate (GHB), Special-K, and others—as well as amphetamines (speed or crystal)—are heavily used and promoted. Fatalities have even been associated with the use of these drugs at some parties.

Alcohol and Drug Use and Sexual Activity

Many people think of gay men as sexually obsessed, in part as a result of the general media's focus on gay male sexual activity and reporting on and concern over human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Gay men are probably no more sexually obsessed or active than males in general, and certainly interest level and activity vary with age. Still, there are important links between sexual activity and alcohol and drug use that add to the risk of gay men developing substance abuse problems and that pose challenges for recovery.

As noted earlier, many gay men may feel particularly ashamed or uncomfortable about having sex with another man. This manifestation of internalized homophobia can lead to sexual activity in inappropriate places such as parks or public bathrooms, and it can strengthen the link between alcohol and drug use and sexual activity.

A small subsection of gay men focus on sexual activity with many partners and/or with great frequency. Many have discovered that using nitrates, cocaine, and, primarily, amphetamines greatly enhances sexual intensity and activity. Amphetamines, in particular, seem to increase and prolong sexual feelings and sexual stamina. Many gay men who use amphetamines also develop a side effect associated with amphetamines—transient

impotence. Sexual desire is still greatly enhanced—for up to 14 hours—thus these men are at greater risk for HIV infection if precautions are not taken.

Gay Male Life Cycles and Relationships

At each stage of their lives, gay men face challenges unique to being gay. **Adolescents** who are gay, bisexual, or questioning whether they are gay or bisexual, for example, face possible taunts or threats from their peers. Their families may reject them, and some gay youth run away from home. Such gay youth may end up homeless and may also get into drug use (especially intravenous [IV] use) and turn to prostitution. Anecdotal reports exist of gay youth who were living on the street attempting to become infected with HIV for the purpose of qualifying for medical and social services as well as disability income and housing programs.

Their suicide risk, including thoughts, attempts, and successful suicides, may be three times that of other youth (Rotheram-Borus, Hunter & Rosario, 1994). Gay youth who do not leave home may also have more problems with schoolwork, sexual abuse, and alcohol and drug use than their nongay counterparts. Experimentation with drugs and sex is likely to be part of the development of gay youth even if they are accepted by family and self-accepting—just as with any adolescent or young adult.

Young gay men and middle-aged gay men may face discrimination and antigay bias in school, at work, and from friends and family. Most gay men form relationships, but same-sex relationships are not readily accepted or even acknowledged in America (Cabaj, 1988; Cabaj & Purcell, 1998). Gay people still are fighting for the right to same-sex marriages. Many gay men have children—by marriage or a relationship with a woman, by adoption, or by a coparenting relationship with a lesbian friend, for example—and face the struggles of raising children with little support from society or even from other gay people. Such pressures may contribute to alcohol and drug use.

Older gay men face the same issues as all older people but may feel more isolated and disconnected from others because of growing up gay at a time of even more prejudice against and denial of gay people. Many gay men, however, have developed strengths from personal networks that serve them well in coping with older life. Some older men will be facing the loss of a long-term relationship; such "gay widows" may have few social supports. Of course, alcohol and drug use may be a major part of an older gay man's life, and he needs interventions appropriate to his age as well as his sexual orientation. The emphasis in gay culture on youthful looks and perfect bodies may also impact the gay man as he ages.

All gay men—all LGBT people in general—also face the possibility of violence and hate crimes directed at them because of their sexual orientation. Such violence ranges from verbal to physical attacks; many victims of such violence turn to alcohol or drug use.

Domestic violence is also a real possibility with gay couples and is greatly underreported. As with all couples, there is a link between alcohol and drug use and domestic violence. Finally, gay people are subject to physical and sexual abuse when growing up and are at the highest risk for alcohol and drug use associated with such abuse (Island & Letellier, 1991).

HIV/AIDS: Loss and Grief

HIV/AIDS continues to be a major factor in gay male life. Though not a "gay disease," HIV/AIDS has long been associated with gay men. Behaviors—risky sex or sharing needles, for example—are the risk factors, not the orientation. Still, gay men are at greater risk, since so many gay men are HIV-infected, and

having sex or sharing needles in an unsafe way with another gay man may increase the risk of exposure to the virus. For more information, please refer to the Center for Substance Abuse Treatment's Treatment Improvement Protocol 37, titled *Substance Abuse Treatment for Persons With HIV/AIDS* (2000).

The percentage of HIV-infected people in the United States who are gay has steadily dropped, but there are still many infected gay men. There are recent increases in the HIV-infection rates in younger gay men, especially in urban areas (Centers for Disease Control and Prevention, 1998).

New infections are, of course, due to exposure to HIV through risky behaviors. Studies of gay men who have risky sex and know about precautions for safer sex report that they were much more likely to have risky sex after alcohol or drug use (Stall & Wiley, 1988).

Almost every gay man has lost friends or lovers to AIDS, and almost every gay man knows someone who is HIV infected. The grief and loss gay men feel and share is profound and has to be a consideration in working with any gay man.

Case Example

Greg is a 28-year-old, hearing-impaired, HIV-infected, Caucasian gay man living in a large west coast city in a "gay ghetto." He works as a sign language interpreter for an AIDS organization. He is single, loves to go to parties, works out at the gym almost every day, and tries to maintain his health by following his HIV medication regime carefully. He loves to go to "circuit parties" and even helped develop a special area for other hearing-impaired participants to meet and sign the announcements made at these events.

He used to drink alcohol, but stopped after he learned his HIV status. He does, however, use crystal meth (amphetamines, speed, crank) to allow himself to party longer and get sexually motivated and aroused. He does not see that as a problem, since he only uses on weekends, has a low sexual drive otherwise because of the many HIV medications and a low testosterone level, and has many friends who do the same thing. He has missed some Mondays and even a few Tuesdays at work, but everyone there assumes these absences are due to his HIV status. He used to snort the crystal but now shoots it intravenously to get a more rapid effect. Again, he does not see that as a problem since he needs to be economical in his use on the weekend—"more bang for the buck." He has a fair amount of sex, usually as a "passive" partner, since the crystal makes it difficult for him to get an erection. Because he is already HIV infected, he says he does not worry about safer sex practices.

Although almost all of his friends also use crystal, a few friends have talked to Greg recently about how haggard he looks and how they think he may be "tweaking," that is, shooting crystal too often. They don't want to tell him what to do, but they also think he should be more careful when having sex because he might infect someone else or get a different strain of the HIV virus. Greg says they should mind their own business because he works for an AIDS organization, knows what he is doing, and can stop the crystal use any time he pleases.

Suggested Interventions

This case points out many of the issues discussed in this chapter—the frequent link between substance use and social activities for gay men, the special role of amphetamines, the concerns about HIV/AIDS. Greg has many reasons to feel different: being deaf, being gay, being HIV positive, having a low sex drive. He has a great deal of denial and will need much support to see the impact of substance abuse on his life. The primary care provider who manages Greg's HIV care may be the best person to intervene. Ideally, all HIV medical providers should be well versed in substance abuse treatment. If the primary care provider is able to refer this client to a substance abuse counselor, the counselor will need to keep many points in mind in the intervention and treatment planning including the following:

1) Denial is part of all substance abuse. Denial seems to be particularly strong with amphetamine use and abuse. Many gay men who use "speed" use it intravenously and still do not consider themselves as having a problem. Point out the current and possible effects of the amphetamine use, such as health problems, loss of time at work, and the concern of friends who want to help break the denial.

2) Many gay men will say they are out and quite comfortable being gay. Although this statement is usually true, gay men have not always addressed the internalized homophobia that they picked up from growing up in a homophobic society. Some gay men, such as Greg, may have very subtle self-esteem problems and not recognize that their drug or alcohol use, poor selection of dates or lovers, or lack of ambition on a job may be related to shame and doubt about being gay. Just being out to others does not mean that someone really has dealt with the issues he has had to live with as a result of growing up gay. The substance abuse counselor working with Greg will have to communicate with Greg about his self-acceptance and any shame and doubt he is dealing with, even if he is out with his close circle of friends.

3) Gay men with disabilities and substance abuse problems face extra barriers to accessing care and to living clean and sober lives. Finding a counselor or program that has other deaf staff or staff who can sign may be difficult. Finding 12-step programs that have services for the hearing impaired may be an additional challenge. There are, luckily, many sensitive programs for hearing-impaired gay people. The counselor working with Greg can help him find a 12-step program with such sensitivity in their local community, since most large cities have specific gay- and lesbian-identified services.

4) If Greg is able to accept the fact that he has a substance abuse problem, ongoing self-care will remain a challenge unless he is able to find new social outlets that do not involve alcohol and drugs or unless he is able to develop new friendships with people who do not have substance abuse problems. Greg's counselor will need to work with him to explore other social avenues or work on a program that will allow Greg to develop the skills to avoid alcohol and drug use in his old social environment. The counselor will have to help Greg talk to his current friends about not bringing him drugs or trying to convince him it is okay to use just a little. It may be hard to make new friends, but it may be necessary. It is also the counselor's responsibility to encourage Greg to engage in safer sex practices and to provide or refer him to information regarding such practices, including their benefits (e.g., preventing reinfection that could forfeit a successful HIV medication regime).

Chapter 9 Clinical Issues With Bisexuals

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What providers will learn from this chapter:

- The myths and misconceptions about bisexuals that might interfere with their treatment
- What substance abuse counselors need to know about bisexual women and men (including transgender women and men who identify themselves as bisexuals) in treatment
- Psychosocial issues unique to bisexuals in treatment

Introduction

This chapter presents information to help providers who treat bisexual clients. The information includes some of the misconceptions about bisexuals that might interfere with their treatment, some of the psychosocial issues that may arise when treating bisexuals for substance abuse, and some counseling strategies effective in treating bisexual women and men.

Counselors working with self-identified bisexuals need to assess their clients' sexual behavior and identity issues and also focus on a range of psychosocial issues that may complicate substance abuse treatment of bisexual clients.

Bisexual identity is not exclusively or necessarily defined by sexual behavior. Indeed, the contemporary conceptualization of bisexuality is that it should be understood as a sexual orientation in and of itself and distinct from heterosexuality and homosexuality. The current view has developed over time. Our understanding of bisexuality has not been historically fixed and, in fact, has shifted along a continuum of validation to a denial of its very existence. Sigmund Freud, for example, writing in 1925, affirmed his belief in "the constitutional bisexuality of all human beings" (Fox, 1996, p. 148) and reaffirmed this again in 1937. In stark contrast Bergler wrote in 1959 that "Bisexuality . . . is an out and out fraud," suggesting that bisexuals were in denial about their homosexuality (Fox, 1996, p. 149). Although it is not uncommon for gay men and lesbians to

look back at their coming out process and recall a time in their lives when they self-identified as bisexual, this does not negate the fact that some individuals clearly are bisexual and that bisexuality can be understood as a distinct sexual orientation.

Myths

For some bisexuals, their bisexual identity is continuous and fixed across their lifespan. For others, sexual orientation may be more fluid and marked by changes from heterosexual to either lesbian or gay or vice versa. This observation may be behind some of the more common myths and misperceptions regarding bisexual individuals.

These mistaken beliefs are prevalent among lesbians and gays as well as among the heterosexual population and unfortunately may also be internalized by bisexual individuals, thus complicating their treatment. Some of the more persistent myths are listed below.

- Bisexuals are confused about their sexual orientation.
- Bisexuals are afraid to be lesbian or gay because of social stigma and oppression by the majority.
- Bisexuals have gotten "stuck" in the coming out process.
- Bisexuals have knuckled under to the social pressure to "pass" as straight.
- Bisexuals are in denial about their sexual orientation.
- Bisexuals are hypersexual and will have sex with anyone.
- Bisexuals are not "fully formed" lesbians or gay men.

Professional Biases *Versus* Research

Since professionals are also influenced by the dominant culture and social environment, service providers may bring their own biases to their work with bisexuals. They may be inclined to view individuals who used to have, or who continue to have, sexual relations with both men and women—transitionally, sequentially, or concurrently—as psychologically or emotionally damaged, as developmentally immature, or as having a personality disorder. Individuals classified under the last category are generally labeled as having a borderline personality disorder, with changing sexual behavior manifesting as a symptom of poor impulse control or acting-out behavior. According to Fox (1996), however, "research has found no evidence of psychopathology or psychological maladjustment in bisexual women and men" (p. 154). After reviewing the literature, Fox reported that numerous studies have found just the opposite. In particular, self-identified bisexuals have been found to possess, among other attributes, high self-esteem, high self-confidence, and a positive self-concept independent of social norms (p. 155).

What Counselors Need To Know About Bisexual Clients

To provide effective treatment to bisexual clients, providers will need to understand that bisexuality is a nonlinear, complex phenomenon. For example:

- A variety of sexual behaviors may be engaged in by bisexual women, bisexual men, and transgender individuals at any time because behavior and identity can be separate issues.
- Bisexual identity may be formed early in one's life and remain intact across the lifespan. This is known as **continuous** bisexuality.

- Desire may be experienced by bisexuals as sexual attractions to same-sex or opposite-sex partners at different times during their lives. This is known as **sequential** bisexuality. For example, a bisexual woman may have engaged in sexual relations exclusively with men in her twenties and in sexual relations exclusively with women in her thirties.

- Bisexuals may express sexual desire toward men and women at the same time. This is known as **concurrent** bisexuality. For example, a bisexual man may be attracted to and will actively date men and women during the same timeframe.

- Women and men (including transgender women and men) who identify themselves as heterosexual may have had, or may continue to have, sexual relations with partners of the same sex.

- Women and men (including transgender women and men) who identify themselves as gay or lesbian may have had, or may continue to have, sexual relations with partners of the opposite sex.

- People of transgender experience, including male-to-female and female-to-male individuals, may identify themselves as bisexual. This is because bisexuality (and sexual identity generally) is a separate phenomenon from gender identity.

Psychosocial Issues

The fact that bisexual identity and bisexual behavior are separate phenomena may be due, in part, to a variety of social factors that mediate between identity and behavior. These variables include the following:

- Race or ethnicity

- Family norms and parental upbringing

- Community or cultural norms and standards, especially culturally constructed gender roles (acting "male" or "female")

- Religious values and beliefs

- Political views (For example, identifying with the majority or with socially oppressed groups may be a political stance. Therefore, some bisexuals may identify themselves as gay or lesbian in order to make a political statement.)

- Legal issues, such as not having the legal sanction of a recognized sexual partnership through the institution of marriage

- Environmental factors, as in the case of individuals in institutions, such as prisons, jails, or exclusive private schools, who may engage in sex with partners of the same sex only while they are in the institutional environment

- Financial considerations, such as the need to engage in prostitution and hustling, especially as a function of substance use, in which individuals are paid to engage in sexual behavior that is inconsistent with their sexual identity.

All of these social factors may result in, or contribute to, separating identity and behavior by bisexual women and men (including transgender women and men who identify themselves as bisexual).

Counselors should develop their sensitivity to these social issues and to issues of gender, age, psychological development, socio-economic status, and modes of sexual expression and desire.

Counseling Strategies

Recovery from substance abuse and addiction for bisexuals will be facilitated by empathetic,

nonjudgmental counselors who support clients in:

- Becoming more self-accepting
- Healing from the shame caused by heterosexism and internalized biphobia
- Referring bisexual clients to either straight or gay/lesbian 12-step fellowships, or both, depending on what is more appropriate to their recovery needs.

Chapter 10 Clinical Issues With Transgender Individuals

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What providers will learn from this chapter:

- The definition of transgender
- The different theoretical models used to describe the development of gender identity in transgender women and men
- Transgender-specific clinical issues
- Treatment "do's" and "don'ts" in dealing with issues related to transgender men and women

Introduction

This chapter presents a brief introduction to issues facing transgender clients and the substance abuse treatment providers caring for them. The chapter provides an explanation of the term transgender, a brief overview of the theoretical models that describe transgender identity development, and the clinical issues specific to transgender clients.

Transgender is an umbrella term that encompasses a variety of people including transsexuals, cross dressers, and drag kings and queens, as well as bigender and androgynous individuals (Tewksbury & Gagne, 1996). Transgender, as a term, came into common usage during the 1980s. Previously, people with mixed gender and sexual characteristics were described as transsexuals and transvestites, terms that come from the psychiatric vocabulary. Transgender comes from the transgender community itself and is, therefore, the preferred term in working with transgender individuals.

The psychiatric model views both transsexuality and transvestitism as psychopathological in nature. Transsexuality is viewed by this model as an insufficient identification with the same-sex parent or overidentification with the opposite-sex parent in infancy or early childhood. Transvestitism, understood as an abnormal dependence on wearing female attire for sexual arousal, was also traced to early

childhood experiences (Warren, 1997; Docter, 1990; Denny, 1994).

In addition, medical models of transsexuality currently are being explored. These models focus on physiological etiology and range from prenatal hormonal effects on the fetus to differences in brain structure. However, neither the psychiatric nor medical models for defining transgender individuals have been accepted by the transgender community.

Research on the various theories of the medical model of transgender experience has led the transgender community to question the role the psychiatric and medical fields play in providing services. In order to avoid malpractice issues, medical doctors currently require two letters from psychotherapists supporting sex reassignment before they will approve a transsexual for sex reassignment surgery. The transgender community strongly advocates that the current psychiatric classification for gender identity disorder (GID), 302.85, should be eliminated from the *Diagnostic and Statistical Manual of Mental Health* (Fourth Edition) (DSM–IV). These concerns have caused a vigorous and ongoing discussion about how well the medical and psychiatric fields serve the needs of the transgender community.

In a society and culture that perceives them as "sick," "abnormal," and having a disorder, it is no surprise that transgender individuals sometimes seek escape from hatred, violence, discrimination, and misunderstanding through the use of alcohol and drugs. Transphobia (the irrational fear and dislike of transgender individuals) is a part of our culture. Because they live in a society that discriminates against them, condones violence against them, and denies them basic civil rights, many transgender individuals have internalized the prejudices of their culture and ended up hating themselves. Substance abuse treatment providers may be some of the few people to whom transgender individuals will talk about their feelings and pain. The substance abuse counselor has an opportunity while helping transgender individuals with their substance abuse issues to refer them to resources to help them cope with their transgender issues.

Definitions

As our understanding of transgender individuals and human sexuality improves, the terminology used by the transgender and medical communities continues to evolve. Substance abuse treatment professionals should use the definitions included here as a guide, with the caution that some transgender clients or health professionals may use slightly different definitions.

Transgender includes a continuum of gender expressions, identities, and roles that challenge or expand the current dominant cultural values of what it means to be male or female.

One's **gender identity** is the gender (male or female) with which one identifies. A person may be biologically male and have a female gender identity (male-to-female, or MTF) or be biologically female and have a male gender identity (female-to-male, or FTM). **Gender role** refers to how individuals present their gender in the world (e.g., through the clothes they wear). The gender one defines as one's identity is a matter distinct from sexual orientation.

One's **sexual orientation** may be described as the sex or gender one is attracted to (see chapter 1). Many MTF transsexuals identify themselves as heterosexual (they are female identified and attracted to men). However, transgender individuals, including transsexuals, may identify themselves as heterosexual, bisexual, lesbian, or gay. Gender identity and sexual orientation are not the same thing, and all people have both. The common misconception about MTF individuals is that they are gay. This is often not true.

The terms "sex" and "gender" are often confused in common usage. **Sex** refers to the biological characteristics of a person at birth, while **gender** relates to his or her perception of being male or female and is known as the **gender role**. Many transgender individuals are born one sex and identify themselves as the opposite gender (for example, they are born biologically male and identify themselves as female).

Intersexed individuals are born with ambiguous biological sex characteristics. These individuals often are put through genital surgery, and their sex is decided by the doctor, sometimes with or without the parents' consent. These individuals may later grow up to have gender identities that are the opposite of the manufactured sex constructed for them at birth and have feelings similar to transgender individuals. An international organization has been formed to help and advocate on behalf of individuals who are born intersexed or with ambiguous sexual characteristics.

Transsexuals are transgender individuals with the biological characteristics of one sex who identify themselves as the opposite gender. There are FTM and MTF transsexuals. Transsexuals usually desire to change their bodies to fit their gender identities. They do this through hormone treatment and gender reassignment surgery (sex change surgery). Transsexual individuals who have embarked on this process are often known as preoperative transsexuals (before the sex reassignment surgery). Transsexuals requesting this surgery must live and work as someone of the gender to which they are changing for at least 1 year prior to surgery and be evaluated by therapists. The costs of hormones, therapy, and surgery are highly restrictive and are not covered by most medical insurance. Some transsexuals identify themselves as nonoperative transsexuals because they have decided not to have surgery, either for medical or for other personal reasons. Transsexuals who are HIV positive are routinely denied surgery, and the surgeries currently available for FTM individuals are not functional or realistic. These nonoperative individuals make up the group most commonly referred to as **transgender**. They live and work as the gender opposite the one they were born with. Transsexuals who have completed their sex reassignment surgeries can and do live as someone with the new gender would and are legally either female or male. They are sometimes referred to as post-op (i.e., postoperative) transsexuals. Most will live as women or men, without being noticed. For personal or political reasons, however, they may continue to identify themselves as transsexuals even though technically they no longer fit the definition.

Cross dressers or **transvestites** are transgender individuals who usually identify themselves as of the same gender as their sex; however, they like to dress in clothing of the opposite sex for erotic or personal pleasure. Although by far the largest category of transgender individuals, they usually live a very closeted existence. Many of them are heterosexual men, married with families, often in stereotypically masculine jobs, who, on occasion, dress as females. A number of national and international organizations exist to provide safe places for cross dressers to meet, usually at social gatherings in private homes or private membership bars or clubs.

Drag queens (i.e., gay men who dress in female clothing) and female impersonators (who perform in clubs or cabarets) are not transgender individuals. The choice that these individuals make to dress in the clothing of the opposite sex is not a matter of gender identity. The same is true of drag kings (i.e., women who dress in men's clothing) and male impersonators.

Bigendered transgender individuals may identify with both genders, or as some combination of both, while **androgynous** transgender individuals usually do not identify with either gender; that is, they identify as neither male nor female.

These general definitions are not meant to be used as diagnostic criteria. In fact, it is extremely important that individuals presenting for treatment be allowed to self-identify whenever possible. Questions about whether someone is or is not a transgender individual should be asked privately and respectfully.

Research Into Substance Abuse and HIV Among Transgender Individuals

The little research that has been done on the prevalence of substance abuse in the transgender community suggests significantly high substance abuse rates. Some of the best information available comes from studies of HIV prevalence.

Substance use also plays a significant role in the high HIV prevalence in MTF transgender individuals (transgender women) (Longshore, Annon & Anglin, 1998; National Institute on Drug Abuse, 1994; Longshore et al., 1993). There are more than 15 studies that concluded that transgender individuals (primarily MTF transgender sex workers) have a high rate of HIV infection.

The most recent study on HIV prevalence in transgender individuals conducted by the San Francisco Department of Public Health AIDS Office (Clements et al., 1998) investigated more than 515 individuals with transgender experiences, which included MTF (sex workers and nonsex workers) and FTM transgender individuals (transgender men). The study showed that

- 35 percent of the MTF transgender individuals in the study tested HIV positive
- 63 percent of the African-American MTF transgender individuals in the study tested HIV positive
- 1.6 percent of the FTM transgender individuals in the study tested HIV positive.

Although the FTM individuals studied had a low HIV prevalence rate, they commonly reported engaging in many of the same HIV risk behaviors as the MTF individuals.

The same study is one of the best available on substance abuse among transgender individuals. It showed a lifetime rate of intravenous drug use of

- 34 percent among MTF transgender individuals
- 18 percent among FTM transgender individuals.

Longshore and Hsieh (1998) found that substance use treatment does influence people's HIV risk behavior. Treatment can help reduce transgender individuals' risk of HIV infection if they remain in treatment; however, discrimination and prejudice against transgender individuals can make access to service agencies and health care resources problematic (Transgender Protocol Team, 1995; San Francisco Department of Public Health, AIDS Office, 1997; Bockting, Robinson & Rosser, 1998; Moriarty, Thiagalingam & Hill, 1998).

A study from Hollywood, California, reported that the drugs most commonly used by MTF transgender individuals were alcohol, cocaine/crack, and methamphetamine (Reback & Lombardi, 1999). In the Clements and colleagues (1998) study conducted in San Francisco, 55 percent of the MTF individuals reported they had been in alcohol or drug treatment sometime during their lifetimes.

In addition, violence and discrimination have been found to have negative effects upon gay, lesbian, and bisexual youth, encouraging substance abuse, prostitution, and suicide (Savin-Williams, 1994; Kreiss & Patterson, 1997; Rodgers, 1995). Garnets, Herek, and Levy (1992) stated that experiences of violence and harassment can significantly affect the

mental health of gay men and lesbians, which in turn could influence their substance use as well as their experience in treatment. Experiences of violence and harassment could similarly affect transgender individuals. Transgender individuals are likely to experience some form of discrimination, harassment, and/or violence sometime in their lives. The first major study (Lombardi et al., submitted for publication) on violence and discrimination against transgender people in the United States found that:

- 60 percent experienced some form of harassment and/or violence sometime during their lives
- 37 percent experienced some form of economic discrimination.

Clinical Issues in Substance Abuse Treatment With Transgender Individuals

Ratner (1993) points out that treating substance-abusing gay men and lesbians means being aware of their unique problems in order for treatment to be effective. The same can be said for transgender substance abusers. Aspects such as societal and internalized transphobia, violence, discrimination, family issues, isolation, lack of education and job opportunities, access to health care, and low self-esteem, among others, need to be addressed in the treatment environment.

Like all potential clients, transgender substance abusers bring a variety of experiences with substances and readiness to change into the treatment setting. Many transgender people have had one or more negative experiences with institutions, including those that provide health care. They may be unusually distrustful of professionals and treatment recommendations. It is vital to remember that these clients, like all clients, need to be met with sensitivity and respect. Clients should be allowed to self-identify and cannot be judged on the basis of their self-identification.

Conducting a comprehensive biopsychosocial assessment is very important with transgender individuals. Because all assessments should be designed to elicit the full spectrum of relevant information, it is appropriate to ask **each** client about his or her sexuality, gender identity, and comfort with his or her sex role. It is vital that counselors avoid the common pitfall of focusing on gender issues as the assumed root cause of the addiction problem. When inquiring about the client's substance use, counselors need to recognize that substance abuse among transgender people can involve multiple patterns of use, misuse, and abuse; that multiple causal variables combine to produce problems; that treatment should be multimodal to correspond to a client's particular pattern of abuse; and that treatment outcomes vary from individual to individual (Lewis, Dana & Gregory, 1994). Using this broader view, treatment providers can better understand substance abuse problems with transgender people and diagnose and treat them less dogmatically.

Another point is to recognize that transgender people will bring unique issues into the treatment setting. Some of these issues are obvious, like the lack of family and social supports, isolation, low self-esteem, internalized transphobia, etc., but other issues may not be as obvious. Getting these other issues to surface will require an environment that is sensitive and nonjudgmental. This is especially true when attempting to access inpatient medical or inpatient substance abuse rehabilitation services. Clinicians working with transgender people must have a solid and reliable referral network that they are sure can work with transgender clients in the most sensitive manner possible.

Hormone therapy is an often overlooked clinical issue. Many transgender clients will be on estrogen or testosterone therapies upon

entering treatment. Clients should not be asked to choose between hormones and substance abuse treatment. Hormone treatment is a standard and accepted medical treatment for transsexuals, and clients should be supported by providers to maintain regular, legally prescribed hormonal treatment under proper medical care without interruption. It is important that both the clinician and the client understand that both estrogen and testosterone therapies can affect mood, especially when taken improperly. There may be additional risks associated with using and/or self-injecting "street" or "black market" hormones. This is a particular concern for transgender men, since testosterone must be injected. Obtaining or using needles may be relapse triggers for clients in early recovery.

The issues and difficulties with inpatient treatment and the placement of preoperative or nonoperative transsexuals extend to housing and homeless shelters. The housing issues that face homeless transgender people are a major issue in recovery. Very often the stigma and discrimination that transgender individuals face in the homeless services system are their justification for reengaging with individuals who are not a positive recovery influence and increase their relapse potential.

Additional relapse triggers or significant clinical issues for transgender clients might include (1) the inability to find, engage in, or maintain meaningful or gainful employment simply because they are transgender; (2) a lack of formal education or job skills because they were forced to leave school or home prior to obtaining those basic skills; (3) being HIV positive, asymptomatic, and healthy and desiring sex reassignment surgery but having trouble obtaining it due to their HIV status; (4) the overall lack of accepting social supports who are sober and positive role models; (5) issues of sexual orientation as well as gender identity; and (6) stress resulting from their invisibility and the dissonance caused by "passing" (blending into the mainstream).

An additional clinical issue is that many substance abuse treatment providers feel they cannot identify or empathize with transgender people, thereby creating a barrier in developing a therapeutic relationship. It is worth noting that many of the issues faced by transgender men and women may be those faced by non-transgender men and women. Many transgender women have sexual abuse histories, have co-occurring eating disorders or depression, or have never been in a sober relationship or experienced sober sex. Due to their particular invisibility, less is known about transgender men, but clinicians might expect to see a variety of men's issues in such clients. To provide the best care possible, it is the responsibility of clinicians to enhance their knowledge of substance abuse issues along with their understanding of any issues that will help clinicians understand the treatment needs of their clients.

DO'S	DON'TS
• Use the proper pronouns based on **their self-identity** when talking to/about transgender individuals.	• Don't call someone who identifies himself as a female he or him or call someone who identifies herself as male she or her.
• Get clinical supervision if you have issues or feelings about working with transgender individuals.	• Don't project your transphobia onto the transgender client or share transphobic comments with other staff or clients.
• Allow transgender clients to continue the use of hormones when they are prescribed. Advocate that the transgender client using "street" hormones get immediate medical care and legally prescribed hormones.	• Never make the transgender client choose between hormones and treatment and recovery.
• Require training on transgender issues for all staff.	• Don't make the transgender client educate the staff.
• Find out the sexual orientation of all clients.	• Don't assume transgender women or men are gay.
• Allow transgender clients to use bathrooms and showers based on their gender self-identity and gender role.	• Don't make transgender individuals living as females use male facilities or transgender individuals living as males use female facilities.
• Require all clients and staff to create and maintain a safe environment for all transgender clients. Post a nondiscrimination policy in the waiting room that explicitly includes sexual orientation and gender identity.	• Never allow staff or clients to make transphobic comments or put transgender clients at risk for physical or sexual abuse or harassment.

Case Example

A 24-year-old African-American pre-op transsexual presents for intake at your residential drug treatment program. She is dressed in female attire and tells you she has been living full time as a female for more than 5 years. She has had a legal name change and has identification that states she is a female. She tells you she is revealing that she is transsexual because she "doesn't want there to be any trouble." She also tells you she has been in treatment before and says she had a very bad experience, including the fact that the staff refused to address her as a female and other clients sexually and verbally harassed her. She says she has a long history of abusing heroin and alcohol and that she is ready to change her life and wants to enter your residential treatment program.

Suggested Interventions

Accept her into your residential treatment program and house her as you would other women in your program. If rooms for women are dorm-type rooms, this should be acceptable. If smaller, more private rooms are available, housing her in a single room is also acceptable. If only group showers are available, have a special time at which she can use them. If individual showers for women are available, this is preferable. Insist on all staff referring to her and treating her as female. She should also find outside support for transgender individuals, if it is available. Address any issues clients have, as you would any other counseling issues, in individual counseling. Staff and client education about transgender and transsexual issues will help alleviate some of these concerns.

Chapter 11 Clinical Issues With Youth

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What providers will learn from this chapter:

- The stresses and challenges experienced by LGBT youth that increase their risk for substance abuse and related health and mental health concerns
- The role of stigmatization in increasing vulnerability to and risk for substance abuse
- How to approach assessment and treatment with LGBT youth

Introduction

Adolescence is a time of significant physical and psychosocial development. As adolescents develop, they rely increasingly on peers for information and support. They must also learn how to deal with boundaries and begin to integrate various aspects of their identity. Experimentation, exploration, and risk taking characterize adolescence, and many adolescents explore the use of alcohol and drugs. In fact, most adolescents have tried alcohol and drugs at least once by age 18 (Johnston, O'Malley & Bachman, 1995). According to the 1998 National Household Survey on Drug Abuse (Office of Applied Studies, 1999) 21.3 percent of youth ages 12 to 17 years reported using an illicit drug at least once in their lifetime, while a Centers for Disease Control and Prevention (CDC) survey found that more than half of high school students reported having at least one drink during the preceding 30 days (CDC, 1996).

Adolescents who use alcohol and drugs are more likely to engage in sexual intercourse, to have sex at younger ages, and to have more partners; they are less likely to use condoms during their sexual activity than youth who do not use alcohol and drugs (MacKenzie, 1993). Many adolescents report using alcohol before sexual intercourse. Of these, more than half report having five or more drinks before having sex, which impairs their judgment and increases the potential for high-risk behaviors such as anal intercourse (Fortenberry, 1995). Adolescents who

use crack cocaine, in particular, are at high risk for HIV infection. A study of HIV-positive adolescents found that two-thirds of girls and more than half of boys reported using crack; of these, four out of five reported exchanging sex for money, drugs, food, or shelter (Futterman et al., 1993).

Because adolescents are developing physically and psychologically, substance use can impair their intellectual, emotional, and social development. Drug experimentation in adolescence may be a part of their development. However, the transition from use to abuse is a maladaptive response defined by a failure to successfully achieve the developmental tasks of adolescence (Duncan & Petosa, 1994).

Alcohol and Drug Use in LGBT Youth

Most of the available research about this population has focused on lesbian and gay adolescents; little information is available on bisexual identity development during adolescence (and related risks). Even less is known about the experiences and needs of transgender youth. Information about substance use among lesbian, gay, and bisexual youth is limited, and there are virtually no studies targeting transgender youth. Early community-based studies of urban gay youth show high rates of alcohol and drug use (Remafedi, 1987; Rotherman-Borus, Hunter & Rosario, 1994), while others show rates that are comparable to adolescents in general (Boxer, 1990; Bradford & Ryan, 1987; Herdt & Boxer, 1993). In a recent study among a multiethnic group of self-identified lesbian, gay, and bisexual youth (N=154; 66 percent gay/lesbian; 31 percent bisexual), 93 percent of females and 89 percent of males reported using licit or illicit substances, with alcohol the most popular licit drug and marijuana the most popular illicit drug (Rosario, Hunter & Gwadz, 1997).

The lack of information is mirrored by a lack of assessment, prevention, and treatment services. Recently, some providers and agencies have attempted to address these gaps (e.g., Ryan & Futterman, 1998; Simpson, 1994; Travers & Schneider, 1996). However, more research is needed on the level of substance abuse among these youth as well as treatment and relapse prevention strategies.

Lesbian, gay, bisexual, and transgender (LGBT) youth use alcohol and drugs for many of the same reasons as their heterosexual peers: to experiment and assert independence, to relieve tension, to increase feelings of self-esteem and adequacy, and to self-medicate for underlying depression or other mood disorders. However, LGBT youth may be more vulnerable as a result of the need to hide their sexual identity and the ensuing social isolation. As a result, they may use alcohol and drugs to deal with stigma and shame, to deny same-sex feelings, or to help them cope with ridicule or antigay violence.

Stigma, Identity, and Risk

LGBT youth have the same developmental tasks as their heterosexual peers, but they also face additional challenges in learning to manage a stigmatized identity. This extra burden puts LGBT youth at increased risk for substance abuse and unprotected sex and can intensify psychological distress and risk for suicide.

Sexual orientation evolves over a period of time. However, studies have documented a decreasing age of identity development and coming out among lesbian and gay youth, with initial awareness of same-sex attraction at, on average, age 10; first same-sex experiences at 13 to 15; and first self-identifying as lesbian or gay (initial "coming out") at around age 15 to 16 (D'Augelli & Herschberger, 1993; Herdt & Boxer, 1993; Rosario et al., 1996). Studies of more recent generations of lesbian and gay youth suggest that the period between becoming aware of same-sex attraction and

self-identifying as lesbian or gay is much shorter than in previous generations (see exhibit 11–1).

Although people may be more aware that an adolescent may be gay, they are generally no more tolerant and may even be less accepting of homosexuality in adolescents. In fact, violence and harassment against LGBT youth appear to be increasing. For those youth who choose to self-disclose or are found out, coping with this stressful life event is most challenging. Adolescents at this point in their lives have not developed coping strategies and are more likely than adults to respond poorly to these stressors. These youth must adapt to living in a hostile environment and learn how to find positive environments (Hunter & Mallon, 1999).

Exhibit 11–1:
Sexual Identity: Age of Onset

Average Age (Years) Event Occurs				
Behavior/ Identity	**Earlier Studies***		**More Recent Studies****	
	Males	Females	Males	Females
First awareness of same-sex attraction	13	14–16	9	10
First same-sex experience	15	20	13–14	14–15
First self-identified as lesbian or gay	19–21	21–23	14–16	15–16

*Studies of adults who remembered their experiences as children and adolescents
**Studies of adolescents who described their experiences as they were happening or right after they happened

From very early ages, children and adolescents are exposed to negative stereotypes about homosexuality. They learn to hide same-sex feelings and attractions to avoid rejection and ridicule. As they begin to realize that they might be gay, these negative stereotypes may increase their feelings of conflict, identity confusion, or even self-hate. Adolescents may repress, deny, or attempt to change these feelings through a range of coping behaviors, including heterosexual activity, use of alcohol and drugs, dating the opposite sex, fathering a child or becoming pregnant, and immersing themselves in sports or school activities.

Youth of color face additional stresses and challenges in integrating their sexual, racial, and ethnic identities (Hunter & Schaecher, 1995; Tremble, Schneider & Appathurai, 1989). Racial and ethnic identities are established at early ages, before a person becomes aware of same-sex feelings that may signal a nonheterosexual identity. Adolescents who may be gay have little support for developing an LGBT identity. At the same time, they interact with three separate communities—including their ethnic or cultural community, LGBT communities, and mainstream culture—none of which provide support for all aspects of their multiple identities. Having to manage more than one stigmatized identity increases the adolescent's level of vulnerability and stress (Greene, 1994). Because ethnic minority communities are important providers of essential emotional and practical support, their LGBT youth are particularly vulnerable to rejection. Openly identifying themselves as gay may jeopardize acceptance by the family and ethnic community of youth. Thus, many youth of color hide their sexual orientation and, as a result, are often less visible than their Caucasian gay peers. Depression and risk for suicide appear to be high for many of these young people (Rotheram-Borus, Hunter & Rosario, 1994).

Most LGBT youth grow up to lead satisfying, productive lives, but some young people are more vulnerable and are at greater risk than others. A past history of abuse and neglect, severe stress, and underlying emotional disorders may influence a young person's ability to cope. Hetrick and Martin (1987) have

suggested that adolescents with these histories may account for the majority of gay youth who attempt suicide or who develop serious substance abuse problems.

Abuse and Homelessness

In the National Lesbian Health Care Survey, lesbians who had been sexually abused, sexually assaulted, or victimized reported significantly more depression and alcohol abuse than lesbians who did not report these experiences (Descamps et al., submitted for publication). Other studies show victims of child sexual abuse are at increased risk for substance abuse (Dimock, 1988; Zierler et al., 1991), suicide (Briere et al., 1988), running away from home (Briere et al., 1988), and HIV infection (Bartholow et al., 1994; Zierler et al., 1991).

Homelessness is a particular concern for LGBT youth, because many teens may run away as a result of harassment and abuse from family members or peers who disapprove of their sexual identity. Still others may be thrown out of the home when their parents learn they are gay. Statistics are not available on the actual percentage of street youth who may be lesbian or gay, but youth service providers agree the percentage is very high, and reports from various studies show ranges from 20 percent to 40 percent (Kruks, 1991; Los Angeles County Task Force, 1988; Seattle Commission on Children and Youth, 1988; Stricof et al., 1991). Homeless youth are at high risk for exploitation. Without an education or job skills, they may become involved with survival sex (exchanging sex for food, drugs, or shelter), drug dealing, or other illicit activities (Clatts & Davis, 1999).

Like their heterosexual peers, LGBT homeless and runaway youth have many health and social problems, often as a result of abuse and neglect. These include serious substance abuse and mental health problems, being at high risk for suicide, sexually transmitted diseases (including being at high risk for HIV/AIDS), pregnancy, and many chronic health problems (Hoffman, Futterman & Myerson, 1999).

LGBT youth are at high risk for antigay violence such as physical attacks, verbal and physical abuse, and harassment (D'Augelli & Dark, 1995; Dean, Wu & Martin, 1992). Youth of color and those who are openly or stereotypically gay are more likely to be victimized, and anecdotal reports suggest that transgender youth may be at greatest risk. Antigay attacks heighten an adolescent's feelings of vulnerability, often intensify a young person's own inner conflict with his or her sexual identity, and may cause the youth and others to perceive the attacks as a punishment for being gay. Lesbians who are victims of hate crimes report significantly higher levels of stress, depression, and alcohol and drug abuse than those who were not victimized (Descamps et al., submitted for publication).

Ironically, while coming out to peers and adults may reinforce adolescents' feelings of comfort about their sexual identity, it greatly increases their risk for violence and harassment, even by their families (D'Augelli, Hershberger & Pilkington, 1998).

Assessment and Treatment

LGBT youth experience countless challenges in attempting to manage their stigmatized identity. Assessment and treatment should address the adolescents' social environment, sexual identity development, stage of coming out, gender identity, support network, impact of multiple identities (such as gender, ethnic, and cultural identities), level of disclosure about their sexuality, and knowledge and use of safer sex practices. Providing safety and giving support are essential elements in prevention and treatment of substance abuse in LGBT youth.

Case Study

David is a 16-year-old gay youth who identified himself as gay at age 12 but did not "come out" to others until he met another gay youth on the Internet last year. His father was a heavy drinker and physically abused David and his mother. His father left home when David was 11. Since then, David has been raised by his mother, a restaurant manager, in a medium-sized city in the Midwest.

David began drinking beer with friends in seventh grade and smokes marijuana when he can get it. Alcohol helps him relax in social situations and makes it easier to pretend that he's straight. It helps reduce feelings of isolation and depression. David was afraid to come out to friends at school and had not told anyone he was gay until he found a gay youth Web site last year. Through the Web site, he connected with other gay teens who provide emotional support. This is David's only source of support and has helped reduce his feelings of isolation, but none of these youth live nearby. His mother usually works on weekends, and David has been able to drink without anyone finding out. His drinking has increased during the last 2 years, and his grades have begun to drop. He has become increasingly irritable, and arguments with his mother are escalating. David was dropped from the track team last year for failing to attend morning practice, but no one at school or home noticed the early warning signs of substance abuse.

David began having sex with young men he met in a public park when he was 14. He did not know how to meet other gay people until he heard someone joking about a park across town. David feels more comfortable having a few drinks before he has sex and rarely uses condoms.

David's experiences are common for gay youth who use alcohol and drugs to cope with loneliness and social adjustment and to medicate themselves for depression and anxiety. Potentially, his substance abuse problem could be identified by a perceptive teacher, school counselor, or pediatrician. In many cases, however, adolescent substance abuse is not identified until youth get into trouble or alcohol and drug use escalates. In David's case, early intervention could help prevent more severe dependency and could help him develop social and interpersonal skills, including the capacity for chemical-free intimacy and for discussing risk reduction with his sexual partners.

Suggested Interventions

Finding drug treatment programs for teens like David is a challenge. Very few resources for drug treatment and aftercare exist for LGBT youth. Hunter and Haymes (1997, p. 156) noted: "With few exceptions, appropriate models for this population have not been designed. And those that exist have not been evaluated. Consequently, these youth are continually forced into straight, traditional drug treatment programs, which almost always fail to meet their needs." Youth care providers and counselors caution that LGBT youth may be harmed by programs that lack appropriate content or experience.

Chapter 12 Related Health Issues

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What providers will learn from this chapter:

- The health concerns of substance-abusing LGBT individuals
- Some of the mental health issues that substance-abusing LGBT individuals face
- What is currently known about interpersonal violence and substance abuse in the LGBT community

Introduction

Once a client begins to address his or her substance abuse problem, he or she may face a variety of additional health problems, some of which may be due to poor self-care. Lesbian, gay, bisexual, and transgender (LGBT) people in recovery have similar health concerns and face many of the same physical and mental health crises as anyone else in recovery. This chapter provides a brief introduction to some of the health problems facing LGBT individuals as they begin their recovery from substance abuse. Health assessments and interventions for substance-using LGBT clients should include the same components as those for other clients and some additional components that are unique to or more common among LGBT individuals.

Many people who abuse substances have co-occurring mental health disorders, such as affective disorders, eating disorders, or other psychiatric illnesses. Substance abuse clouds judgment and contributes to hazardous behaviors that can lead to illness, such as HIV/AIDS, sexually transmitted diseases (STDs), hepatitis, and injuries. People who abuse substances may have neglected their health and nutrition and may smoke cigarettes. Some may have been the victims of domestic violence or hate crimes resulting in posttraumatic stress disorder. When considering these factors, providers of substance abuse treatment for LGBT clients should, as with any client, screen for other

health problems—for possible co-occurring mental disorders, poor nutrition, poor dental care, liver disease, STDs, HIV/AIDS, violence, sexual abuse, and incest. In this way, substance abuse treatment providers can assist their LGBT clients in accessing appropriate medical care and treatment for their health and mental health concerns.

The abuse of alcohol and other mood-altering substances can also affect the treatment of HIV/AIDS. For example, substance abuse and its associated mental impairments can interfere with clients' ability to comply with very complicated medicine regimens. Strict adherence is crucial to the effectiveness of the powerful new medications used to combat HIV. Substance abuse also affects clients' ability to take their medication properly.

Gay and Bisexual Men

Gay and bisexual men who are sexually active with multiple partners are more susceptible to STDs and HIV/AIDS. Substance-abusing gay and bisexual men may be at an even greater risk for infection than non-substance-abusing gay and bisexual men if their substance abuse disinhibits safe sex practices. Moreover, even when men refrain from high-risk activities, such as unprotected anal sex, they may engage in other activities, such as unprotected oral sex, that likewise increase their risk for STDs, such as gonorrhea and chlamydia. Gay and bisexual men may be exposed to STDs at multiple sites, such as the pharynx and rectum, and may be at risk for anal trauma or the human papilloma virus. Thus, screening these men for all STDs and HIV is recommended. Screening for syphilis is recommended as well because it is often asymptomatic and is increasing in incidence.

Gay men are at higher risk for hepatitis A and hepatitis B through sexual contact. Hepatitis C also may be spread by sexual contact, although transmission via infected needles is probably a far more significant route and is of concern to all injection drug users. All clients should be referred for vaccination for hepatitis A and hepatitis B as a public health measure.

Because so much of the focus for gay and bisexual men is on STDs and HIV, other significant health risks often are neglected. However, as for all men, cancer and heart disease remain the most significant causes of death and morbidity. High stress and smoking may increase these risks. It is especially important to advise clients of these risks and the importance of prevention and regular medical screening for these conditions.

Lesbian and Bisexual Women

Even though research about the health issues of lesbian and bisexual women has increased during the past decade, knowledge of many of their health concerns, including substance abuse, is still limited. It is known that substance-abusing lesbian and bisexual women have many medical risks similar to those of substance-abusing heterosexual women. Alcoholic women tend to have higher rates of fatty liver disease, alcoholic hepatitis, and cirrhosis (Woolf, 1983), as well as a higher risk of muscle weakness, muscular pain, and osteoporosis (Woolf, 1983). Because the majority of lesbians have had heterosexual intercourse—often without birth control or protection against STDs—they are at risk for both pregnancy and STDs (O'Hanlan, 1995). Research information is limited, but some STDs, such as the human papilloma virus, bacterial vaginosis, and Trichomonas, can be transmitted among women, although female-to-female transmission of HIV is extremely rare (only two cases have been reported). Lesbian and bisexual women who use injectable drugs are at high risk for hepatitis B, hepatitis C, and HIV/AIDS and should be screened for these diseases. Some lesbian and bisexual women may be sex workers and may have been exposed to STDs, HIV, and trauma.

For lesbians, negative experiences with health care providers and the lack of providers who are knowledgeable about lesbian issues may have been a barrier to proper diagnosis and treatment. In addition, some experts speculate that lesbians may have an increased risk for specific health problems, such as cancers of the breast, colon, and ovaries; endometriosis; and bacterial vaginitis. These higher risks are based on factors such as a higher fat intake, alcohol abuse, not bearing children, and inconsistent medical care (O'Hanlan, 1995). Providers may not test for STDs and pregnancy, incorrectly assuming that lesbians do not have sex with men. Moreover, lesbians may be offered pap smears less often than heterosexual women, presumably because doctors assume they do not need them as often (Kerner, 1995).

Transgender Individuals

The health concerns of transgender individuals are numerous. A study of 500 transgender individuals in San Francisco (Clements et al., 1998) showed a 35-percent HIV prevalence rate among male-to-female (MTF) transgender individuals and a 65-percent HIV prevalence rate among African-American MTF transgender individuals. More than 15 additional studies showed similar high rates of HIV infection in transgender individuals who were primarily MTFs in the sex industry and also at high risk for substance use. These findings underscored the great need for prevention and appropriate care for this underserved population.

MTF and FTM (female-to-male) transgender individuals also face the risks associated with hormones, alcohol, and drugs. A particular concern is FTM hormonal use, because male hormones are injected. The use of needles raises the risk of hepatitis C and ovarian cystic syndrome and may increase the risk of injectable substance relapse. Hormones can damage liver function and, with the added effects of alcohol and drugs, the combinations may be even more harmful. Indeed, increased risks of liver cancer and cirrhosis have been noted in the medical literature regarding hormones and alcohol and drugs.

Common Barriers to LGBT Individuals Receiving Adequate Health Care

LGBT individuals have been marginalized by some segments of the health professions. Historically, their sexual orientations and gender diversity were labeled deviant or pathological by many in the medical and psychiatric community. As a result, many gays and lesbians do not disclose their sexual orientation to their health care providers (Cochran & Mays, 1988). Consequently, many LGBT individuals, particularly transgender individuals, are reluctant to use mainstream health care services and are medically underserved. However, LGBT health advocates and professionals have lobbied for changes in mainstream professional organizations that have resulted in policy statements addressing the needs of LGBT clients and the formation of official LGBT affiliates, such as the American Psychological Association's Task Force on the Status of Lesbian and Gay Psychologists and the American Psychiatric Association's Committee on Gay, Lesbian, and Bisexual Issues. Although these changes have been important steps in establishing ethical guidelines for appropriate care, many health and mental health treatment providers remain uncomfortable with sexual diversity and continue to discriminate against LGBT clients.

A 1994 survey of the membership of the American Association of Physicians for Human Rights (now called the Gay and Lesbian Medical Association) (1994) found that, of 711 members, 52 percent had observed the denial of care or the provision of suboptimal care to lesbian and gay clients. Eighty-eight percent heard colleagues make disparaging remarks about their lesbian and gay clients. However, 64 percent of the members stated that it is

important for clients to reveal their sexual orientation but also noted they risk receiving substandard care when doing so. Transgender individuals are even more marginalized and are often denied care, and LGBT individuals of color may experience racial bias in addition to homophobia. Thus, sensing these prejudices, many LGBT persons have not used the health care system adequately.

Their hesitation to seek health care may result in later diagnoses of illnesses, which results in poorer treatment outcomes. Many physicians are ignorant of the special health concerns of LGBT individuals, such as the possibility of anal warts in gay men or the surgical and hormonal treatment options for transgender individuals.

Common Mental Health Issues That LGBT Individuals May Face

Substance-using LGBT clients struggle with mental health concerns and illnesses similar to those of their heterosexual counterparts. They suffer from affective disorders, posttraumatic stress disorder (PTSD), sexual trauma, suicidal ideation and behaviors, eating disorders, and the full range of mental disorders.

However, LGBT individuals have the added stress of struggling to consolidate stigmatized sexual or gender identities, making choices about coming out to family and friends, fear of prejudice, and being at increased risk of violence. In general, researchers suggest that individuals who feel more comfortable about their sexuality and gender identity are more resilient, have better coping skills, and are better able to articulate their mental health needs. However, many clients in substance abuse treatment may not be out and may be very uncomfortable with their identity. This presents several stumbling blocks for the counselor and the client, including the possibility of inappropriate counseling and an increased risk of relapse. Research on the mental health needs of lesbians and gay men has increased substantially during the past two decades. However, significant gaps still exist. The process of coming out as a lesbian or gay man can be extremely stressful, yet there is virtually no research on effective ways of coping with this process, and there has been even less research on the mental health of lesbians and gay men who are nonwhite, adolescent, elderly, or coping with disabilities (Rothblum, 1994). There is also very little research on bisexual and transgender individuals. However, some suggest that many transgender individuals struggle with low self-esteem, depression, and fear about the reality of their vulnerability to personal violence.

Past sexual abuse and trauma may well lead to other mental illnesses, such as PTSD, and complicate treatment for substance abuse. For example, an outcome study of lesbians and gay men who had completed inpatient substance abuse treatment found that 44 percent had been sexually abused (37 percent of males and 67 percent of females) and abstinence was much more likely among those who had not experienced abuse (Ratner, Kosten & McLellan, 1991).

Interpersonal Violence in the LGBT Community

Historically, differences in philosophy and terminology have blocked collaborative care for clients involved in both interpersonal violence and substance abuse (CSAT [Center for Substance Abuse Treatment],1997c). Interpersonal violence has been defined as the use of intentional verbal, psychological, sexual, or physical force by one intimate partner to control another (CSAT, 1997c). Nonetheless, a marked link between interpersonal violence and substance abuse is well documented (Pernanen, 1991; Windle et al., 1995; Bennett, 1995). Up to one-half of the men who commit acts of interpersonal violence also have substance abuse problems (Gondolf, 1995;

Leonard & Jacob, 1987; Faller, 1988), and women who abuse alcohol and other substances are more likely to be the victims of interpersonal violence (Miller, Downs & Gondolfi, 1989; Bureau of Justice Statistics, 1994; Stark & Filcraft, 1988; Gorman et al., 1995).

Less is known about the relationship between substance abuse and interpersonal violence in the LGBT community. Perhaps the LGBT community has been reluctant to call attention to the issue of interpersonal violence out of concern for reinforcing the stereotype that homosexuality is inherently dysfunctional. Fortunately, the seriousness of interpersonal violence has finally been acknowledged by the LGBT community over the past decade (Elliot, 1996). The first account of lesbian battering was published in 1986 (Lobel). Experts estimate that interpersonal violence occurs at about the same rate in same-sex relationships as in heterosexual relationships (Island & Letellier, 1991; Lobel, 1986). Rates of partner violence range from 8 to 46 percent (Elliot, 1996). The National Lesbian Health Care Survey (Bradford, Ryan & Rothblum, 1994) showed an 8-percent rate of partner violence in a diverse, nonclinical sample of nearly 2,000 lesbians. In a study of 90 lesbian couples, 46 percent of the couples experienced repeated acts of violence in their relationship (Coleman, 1990). And of 1,000 gay men surveyed in the Northstar Project, 17 percent reported having been in a physically violent relationship (Gay and Lesbian Community Action Council, 1987).

In a study of 228 gay male perpetrators, Farley (1996) found the following contributing to gay interpersonal violence:

- 40 percent abused drugs.
- 87 percent had previous mental health treatment.
- 93 percent reported physical abuse as a child, and 67 percent reported sexual abuse as a child.
- 53 percent reported physical abuse as an adult.
- 40 percent reported alcohol abuse in their family of origin.
- 80 percent had a previous history of being an abuser in an adult relationship.

Assessment

Substance abuse in the LGBT community has been exacerbated by internalized homophobia (Ghindia & Kola, 1996) so that many LGBT individuals feel isolated and victimized. The isolation may be intensified further by mistrust of treatment providers and a lack of civil rights protection. Seeking professional or legal help for interpersonal violence is equivalent to coming out (Elliot, 1996). These barriers may make it more difficult to identify LGBT victims or perpetrators of interpersonal violence. Consequently, LGBT clients in substance abuse treatment should be screened to identify both batterers and survivors of interpersonal violence (CSAT, 1997c). Indicators of interpersonal violence include the presence of physical injuries, especially in visible areas, inconsistent or evasive answers regarding injuries when questioned, a history of relapse or noncompliance with substance abuse treatment goals, and stress-related conditions and illnesses (CSAT, 1997c).

As with all clients, practitioners should gather information about the partner's treatment of the client. Interpersonal violence may be a factor if the client states that the partner tries to isolate him or her socially, tries to prevent him or her from attending treatment or self-help programs, threatens to abandon him or her, or damages property.

The practitioner should ask questions in an affirming and culturally sensitive manner. Establishing rapport and trust is critical in accurately gathering sensitive information. Care in selecting words and phrases that reflect sensitivity to LGBT issues is imperative. Potentially difficult questions should not be raised too quickly or the client may feel overwhelmed or threatened and refuse to cooperate.

Clients should always be interviewed about interpersonal violence in private, even if the client requests the presence of another individual who is not the batterer (CSAT, 1997c). Putting the client at risk by interviewing him or her in the presence of others should be avoided because batterers may manipulate family members and others.

Practitioners should include questions about sexual abuse that reflect their sensitivity to LGBT concerns. Questions about the client's family of origin should be posed in a way that helps the client speak openly. When working with LGBT individuals, the service provider should help clients feel safe and assure them that confidentiality is respected. These issues frequently provoke great discomfort in all clients, and LGBT clients may feel additional discomfort because of some apprehension about mental health practitioners in the LGBT community.

Screening of possible batterers should be conducted with the same emphasis on confidentiality, safety, and cultural sensitivity. The practitioner should ask clients about abusive behavior using the technique of circumstantial violence (Kantor & Strauss, 1987). Simply put, this involves using a third-person example so as not to personalize the question, thereby making the client defensive. For example, "Some people think that under the right circumstances, it's okay to hit your partner. Under what conditions do you think violence might be justified?" (CSAT,1997c).

Then the practitioner could begin personalizing the questions assessing self-control. For example, "If you were confronted with overwhelming stress, do you think you could keep your cool? Faced with that, what do you think you would do?" (CSAT, 1997c).

Questions should be supportive and affirming, thereby encouraging genuine responses. Gradually, the practitioner should ask specific questions about the relationship, e.g., "Have you ever hurt your partner?" It is critical to recognize that denial, rationalization, and minimization are strong mechanisms used for both interpersonal violence and substance abuse. Thus, it is critical that the practitioner guard against being manipulated or misled by excuses and that batterers be held responsible for their actions (CSAT, 1997c).

Finally, the treatment provider should avoid colluding with clients in denying the implication that substance abuse causes interpersonal violence. Practitioners should watch for clients who blame others for their battering or substance abuse. For successful treatment outcomes, clients must take full responsibility for their behavior.

Interventions

If a client is identified as either a batterer or a survivor of interpersonal violence, he or she should be referred to a support group, to a batterers' intervention program, and for ongoing consultation with an expert in the treatment of domestic violence (CSAT, 1997c). Exactly how to refer survivors depends on the situation. If immediate danger is present, suspend the interview. The provider should be familiar with deescalation methods and have established links with other treatment providers and police (CSAT, 1997c). The practitioner should be aware of available resources with expertise in interpersonal violence and LGBT issues.

Past trauma has been associated with subsequent substance abuse. For many in the LGBT community, trauma not only results from childhood physical and sexual abuse but also from internalized homophobia, cultural heterosexism, and gay bashing. It is important for the practitioner to consider these issues as LGBT clients move toward abstinence because they can be powerful relapse triggers.

Just as substance abuse does not cause or excuse violent interpersonal behavior, HIV infection does not cause battering. Unfortunately, many in the LGBT community who are assaulted by their HIV-infected partners blame the stress of HIV infection for the violent behavior (Letellier, 1996). Treatment providers should not collude in this denial of responsibility and should consider the comorbidity of HIV infection, interpersonal violence, and substance abuse in planning assessments and interventions.

The treatment for both substance abuse and interpersonal violence should be conducted concurrently. The fundamental goal of treatment for both is to create, nurture, and strengthen the individual's capacity to maintain intimate relationships that are free of violence (Byrne, 1996) and substance abuse.

The skills used in assessing substance abuse are useful for assessing interpersonal violence, regardless of the client's sexual orientation. A practitioner is likely to encounter the same defensive strategies (e.g., denial, defensiveness, blame). Assessment and intervention strategies do not require new theoretical approaches or skills. However, the practitioner must consider the safety of the victim and perhaps the practitioner's own safety when intervening. The same competencies and approaches can be used with LGBT individuals. Successful treatment outcomes for LGBT individuals depend on creating an open and trusting atmosphere, taking care not to make hetereosexist assumptions, and having an understanding of the importance of confidentiality and disclosure issues. Working with LGBT individuals requires a thorough knowledge of the effects of cultural heterosexism on the LGBT client and the use of existing empirically derived practice skills.

Case Example

Ron, a 34-year-old African-American male, presents to your substance abuse treatment agency at the insistence of his employer for alleged difficulties at work. Apparently, he has come to work late on numerous occasions with alcohol on his breath. During his assessment, he informs you that he has been drinking excessively over the past few months and, as a result, has been unable to get to work on time. He also vaguely reports engaging in high-risk sexual behaviors. During the assessment, you notice black and blue marks on Ron's arms and neck. He tells you that for about 3 years he has been living with another man who recently has been diagnosed with HIV and now has symptoms.

How would you proceed with the assessment? What questions would you ask and how would you ask them?

Suggested Interventions

- Conduct a standard substance abuse assessment.
- Attempt to connect interpersonal violence, the stress of being in a relationship with someone with HIV, and substance abuse using LGBT-sensitive language. This may help the client gain insight and create an environment conducive to further discussion.
- Include questions about a history of family abuse or posttraumatic stress disorder and current relationship issues such as ways of expressing anger and frustration, issues of power and control, and issues of gender roles.
- After establishing sufficient rapport, mention that interpersonal violence is not uncommon in relationships. Do not assume because the client has a bruise that he or she is the victim.
- Take steps to ensure the safety of the client if he or she is in danger.
- Conduct interventions for substance abuse and interpersonal violence concurrently, if possible, within the same organizational structure.
- Ensure that a female batterer of a lesbian in a women's shelter cannot gain access to the shelter.
- Refer clients promptly to a practitioner or an agency that has expertise in interpersonal violence and that is sensitive and knowledgeable about LGBT issues.

Case Example

Deedee, a 52-year-old African-American lesbian, reported to her substance abuse treatment counselor that she found a painful lump in her breast. The counselor knew that Deedee had not seen a doctor in more than 5 years and that she was extremely tense around health care providers. Deedee has a history of childhood sexual abuse and is not comfortable with anyone touching her. She has had bad experiences with health care providers and has been treated disrespectfully because of her lesbian identity. Her counselor was quite concerned about the pain Deedee was experiencing but unsure what to do.

Suggested Interventions

Health care workers and substance abuse counselors should recognize that some of the health care concerns of LGBT individuals are a product of past bad experiences with health care providers. There are a number of ways that helping professionals can address these problems with their clients. For example:

- The counselor should ensure that Deedee is aware of the importance of being evaluated and treated for her potentially life-threatening condition.
- Substance abuse treatment programs should develop partnerships with LGBT-sensitive primary care physicians and clinicians, therapists, and psychiatrists for referring clients to other practitioners who provide sensitive care.

Other suggestions include:

- Help LGBT clients be more comfortable in disclosing their sexual identity.
- Integrate LGBT-inclusive language and lifestyles into curriculums.
- Use gender-neutral questions, and communicate a nonjudgmental attitude.
- Make sure the health practitioner takes a sensitive but thorough sexual history to determine the appropriate STD screening and treatment if necessary.
- Focus risk-reduction education not only on HIV and other STDs but hepatitis as well.

Chapter 13 Counselor Competence in Treating LGBT Clients

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What providers will learn from this chapter:

- How counselors can become more aware of their homophobia and heterosexism, how these biases can lead to mistreatment, and how to monitor and manage their own biases
- How to provide good quality, fair, ethical, and competent treatment to LGBT clients
- How to provide LGBT-sensitive treatment
- What counselors should consider in treating LGBT criminal justice clients

Introduction

Counselors will encounter and provide treatment to lesbian, gay, bisexual, and transgender (LGBT) clients in all treatment settings: residential, intensive outpatient, outpatient, crisis intervention, and the criminal justice system.

The Center for Substance Abuse Treatment (CSAT) published a Technical Assistance Publication (TAP) in 1998 titled *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, in which the professional addictions counseling field, represented by leaders of national counseling organizations, identified eight practice dimensions. The dimensions are (1) clinical evaluation, (2) treatment planning, (3) referral, (4) service coordination, (5) counseling, (6) client, family, and community education, (7) documentation, and (8) professional and ethical responsibilities. Proficient knowledge and skill in each of the dimensions is necessary for effective practice (CSAT, 1998b). The development of effective counseling practices in the field of addictions depends on the presence of attitudes in which openness to alternative approaches, appreciation of diversity, and willingness to change are present and consistently practiced (CSAT, 1998b).

In the counseling competencies model, a counselor needs to respect the client and his or her frame of reference; recognize the

importance of cooperation and collaboration with the client: maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with client characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and nonjudgmentally and respectfully accept the client's cultural, behavioral, and value differences. These best practice methods are critical when working with LGBT clients.

The most important ethical issue in counseling is the protection of clients' well-being and safety, based on an "ethos of care" and a "covenant of trust" between clients and counselors (Peterson, 1992). In this capacity, counselors acknowledge and manage the power accruing to them so that they can use that power constructively and ethically (Gartrell, 1994). Thus, counselors need to be aware of how clients who have been or are being discriminated against may respond to others' power. Clients who have been traumatized may be overly passive and accepting or very oppositional. These behaviors are important information for the counselor, and an aware counselor will provide a safe environment for the client in which to work through his or her feelings. Counselors need to be aware of and monitor their use of authority so that they do not push or force clients to do something they are not ready to do. In the case of LGBT clients, counselors should not "out" or push a client to share his or her sexual orientation or gender status in the name of honesty and good treatment.

At the same time, the counselor should help create a safe environment for clients who are ready to come out in treatment to do so. Counselors need to use their authority to ensure their LGBT clients' safety when it is necessary to protect LGBT clients from overt expressions of homophobia (or biphobia or transphobia) by other clients or staff. Most clients who present for treatment have to deal with the shame and guilt of their drug-using behavior. It is important for counselors to remember how their words can activate clients' shame; this is especially important when working with LGBT clients, who have been traumatized by both their alcohol or drug abuse and the heterosexist attitudes and behavior they must deal with.

Counselor's Professional Responsibility

In the counseling competencies model, a counselor is responsible for self-monitoring, obtaining proper supervision, and adhering to professional and ethical standards. Establishing the proper ethos of care for LGBT clients requires that counselors be aware of and work though their own feelings about these clients.

Self-monitoring is the means for accomplishing this task. Counselors should be aware of countertransference. Counter-transference is the process of counselors seeing themselves in their clients, overidentifying with their clients, meeting their personal needs through their clients, or reacting to a client because of unresolved personal conflicts (Corey, 1991).

Recognizing the manifestations of countertransference reactions is one of the most essential elements of effective counseling. Unless counselors are aware of their own conflicts, needs, assets, liabilities, beliefs, and values, they might use the counseling process more for their own purposes than for their clients'. This self-monitoring is very important when working with LGBT clients. Counselors need to examine their beliefs about lesbians, gay men, bisexuals, and transgender people because their own beliefs underlie countertransference.

Some important questions counselors need to ask themselves are the following:

- Are there myths and stereotypes about LGBT people that I believe? Do I, for instance, believe that gay men are child molesters? That LGBT people try to recruit others, especially children, to their orientation and lifestyle? That lesbians, gay men, and bisexuals would all choose to be heterosexual if they could? That transgender people want to change genders because they are really homosexual?

- Do I believe that having sex with someone of the same sex or having sexual feelings toward someone of the same sex indicates that the person is lesbian or gay? Do I believe that the sexual act, by itself, constitutes sexual orientation or identity? Do I believe that having a lesbian or gay or bisexual or transgender orientation is unnatural, immoral, sick, or disgusting?

If counselors agree with any of these questions, there is a real need for education, training, supervision, and consultation before they work with LGBT clients because their ability to fairly and competently treat LGBT clients is questionable. Unless these counselors are actively seeking to change or alter these beliefs, they should not treat LGBT clients.

A method of managing countertransference issues, prejudices, and difficult clients is by supervision. Supervision provides the counselor the opportunity for processing experiences with clients that may be problematic and may be creating anxiety that can interfere with the counseling process. If a counselor is aware of negative feelings about LGBT clients, it is imperative that those issues are taken to supervisors and worked through immediately. If a counselor is aware of his or her prejudicial behavior toward an LGBT client, he or she should be willing to behave differently or transfer the client to someone who is comfortable working with that client.

Helping Clients Heal From the Negative Effects of Homophobia and Heterosexism

Neisen (1993) discusses the process of recovering from shame associated with heterosexism. Counselors who want to help their clients heal from homophobia and heterosexism may find the following steps helpful.

Breaking the silence parallels the process of coming out. It is important for LGBT individuals to tell their stories and to address the pain of being different in a heterosexist society. The counselor can:

- Encourage a discussion of how the client hid his or her LGBT feelings from others

- Explore the emotional costs of hiding and denying one's sexuality

- Discuss attempts the client has made to change in an effort to fit in

- Examine negative feelings of self-blame, feeling "bad" or "sick," and the impact of shaming messages on the client

- Foster the client's courage to accept and speak up about who he or she is.

Establishing perpetrator responsibility allows clients to understand their struggle in the context of discrimination and prejudice. The counselor can:

- Help clients manage anger in a constructive manner rather than direct it toward themselves

- Help clients understand that anger and a negative self-image are the result of cultural victimization and not a personal defect

- Shift clients' perspective by drawing parallels to the process of recovery from physical or

sexual abuse—recognizing that they have suffered a form of abuse

- Ensure that the treatment environment fosters behavior by staff and clients that is not hostile to LGBT individuals—a difficult task in the case of subtle or covert behaviors.

Reclaiming personal power involves helping clients:

- Improve their self-concept and self-confidence
- Identify internalized negative messages that result from cultural victimization and heterosexism
- Change negative messages to positive, affirming statements about themselves
- Find positive, affirming expressions for spirituality to combat any negative messages about their own morality that clients may have received
- Recognize residual shame and a victim mentality and begin to release it
- Integrate public and private identities
- Build a support network of individuals who accept and value them for who they are.

Practical Suggestions for Providing Competent Treatment

How can a counselor self-monitor when treating LGBT clients? The first issue is what counselors and agencies, via construction of psychosocial histories and intake forms, ask or do not ask clients at intake. If clients are routinely asked about partners or significant others, but this question is omitted with LGBT clients, LGBT clients lose the opportunity to tell their counselor who they really are. Some LGBT clients may not want to reveal their sexual or gender orientation, but if counselors do not ask, they may treat the client's "false self" (Winnicott, 1965), that is, the self that is presented to the world to protect the identity that is repressed and stigmatized. Treating the false self, by not asking about sexual orientation in an accepting and nonjudgmental way, is acting unethically and does a disservice to the client.

Following are some guidelines, or "do's and don'ts," for counselors who are or who wish to be sensitive to the needs and feelings of their LGBT clients and improve their own treatment and counseling skills.

Do's

- Do create safety for LGBT clients. This can include clearly stating what you can and will hold in confidence and what you will share with your team or your supervisor; assuring clients of your own supportive attitudes; and protecting LGBT clients from others' homophobia.
- Do know the population. Read about LGBT people. Get to know LGBT people, especially those in self-help groups and nonclients. Know what LGBT resources are available for clients and how to access them. Recognize that it is easy to shame LGBT clients because of their internalized homophobia and their substance abuse.
- Do create an atmosphere that is supportive. On forms and in all verbal interchanges, use inclusive language. For example, instead of asking about marital status, ask who the partner or significant other is. Instead of asking for the names of next-of-kin in case of emergency, ask for the name of the responsible party and that person's relationship to the client.

- Do acknowledge clients' significant others and encourage their participation in the treatment. Hang pictures and posters of known LGBT people (e.g., athletes, historical figures); have books about LGBT subjects on tables and in waiting rooms; post lists of LGBT-friendly Alcoholics Anonymous/ Narcotics Anonymous/Al-Anon/Adult Children of Alcoholics meetings in visible places.

- Do be guided by your LGBT clients. Listen to what they say is comfortable for them. Support them in making decisions about coming out, self-disclosing, or accepting their identity.

- Do get training to help you become less heterosexist and increase your knowledge and understanding.

Don'ts

- Don't label your clients. For example, when a client says he is in a long-term relationship with another man, do not say, "Oh, then you must be gay." It is for the client to label himself or herself.

- Don't pressure clients to come out. Respect their sense of where they are in this process and their need to feel safe.

- Don't ignore significant others and family members. Don't assume because people are not related by blood or marriage that they are not extremely important to the client.

- Don't interpret on behalf of the client by saying "It must be hard being a lesbian," or "You must be angry because your parents don't accept your being a person of transgender experience." Follow the client's lead. A comment that is empathetic in one context may be invasive in another.

Treating LGBT Clients in the Criminal Justice System

Treating LGBT clients in the criminal justice system presents special challenges for the counselor who has to balance security protocols with maintaining his or her professional and ethical responsibilities. It is especially important that counselors present themselves in a manner that gains clients' trust so that the clients can process issues that may involve their sexuality or gender identity.

In the correctional institution setting homophobia, transphobia, and heterosexism are even more prevalent than in society in general. Stigmatization is more intense, resulting in extreme "closeting" on the part of many incarcerated LGBT offenders. The LGBT offender's sexuality, if known, may be considered an attribute of his or her criminality. This is an issue that should be processed appropriately in treatment.

Some incarcerated LGBT offenders express themselves by clear and flagrant presentation while others choose to hide their sexual orientation or gender identity to avoid punitive consequences from other prisoners. LGBT couples may state to their fellow inmates that they are strongly committed to each other and are monogamous.

Treatment documentation and security of records are important. Counselors may find it helpful to inform their immediate clinical supervisor about LGBT cases and provide progress reports and assistance in managing issues such as clients who are used to being out and open but are forced while incarcerated to hide their identities.

A history of rape, family-of-origin issues, and unresolved grief are prevalent in incarcerated LGBT clients. Due to the homophobia/ transphobia/heterosexism of institutional staff and the other offenders, incarcerated LGBT

clients may have trouble bonding with other LGBT offenders. These clients usually present with profound feelings of isolation, fear, depression, and anxiety and have difficulty trusting others.

Most correctional facilities endorse the traditional 12-step model of treatment in conjunction with "therapeutic community" treatment. In most of the settings, an LGBT-specific 12-step support group will not be available for the LGBT client. Rational-emotive therapy is also utilized in many correctional settings, and counselors should not give the impression that LGBT clients' sexual orientation is a negative "behavior" that needs to be "changed."

Before an LGBT client is released, his or her counselor may be the only professional who can adequately provide the specific referrals needed by the client for community reentry. This is a case management function, and the referrals and recommendations made by the counselor are crucial to helping the LGBT client reenter society and stay clean and sober.

Case Example #1

Yoko was out as a lesbian while going through treatment in a 14-day inpatient facility. Because some of the other clients were homophobic, she was subjected to ridicule, vicious insults, and some threats. Although Yoko managed to stick it out and get some help with her addiction, she was clearly harmed by her experience, both by the direct homophobia of her fellow clients and by the staff's homophobic attitudes and inability to help and protect her. Not only did this experience harm Yoko, but it also affected Sally, a closeted lesbian. Sally observed the abuse perpetrated on Yoko but was too terrified to help. She felt terrible about herself for not speaking out, but she was confused by her anger at Yoko for making treatment more difficult.

Suggested Interventions

The counselors should have addressed the homophobia of the other clients and helped them look at it and stop the antigay behavior. Such prejudice and bad feelings are harmful not only to the recipient and the identifying bystander but also to those harboring and acting on such malicious feelings.

Case Example #2

John is a 43-year-old male who acknowledged his homosexuality several years ago after years of trying to deny his sexual attractions to other men. When John was a child, his parents suspected he was gay because he did not show much interest in "male" activities. When he was 15 years old, his parents sent him to a prestigious hospital hoping that he would be "cured" of his homosexuality. John returned to school and did what was expected of him: He played sports and dated. He thought that perhaps his psychiatrist was right, that his homosexuality "was just a phase." He was a good student and had a small group of friends. He dated several girls, but he never felt romantically or sexually attracted to them. After graduation, he attended college and found his attraction to men was intensifying. John married in his senior year in college, thinking that maybe if he "met the right girl and settled down," these feelings would go away. Over the years, he and his wife had two children. Nevertheless, John's same-sex attractions increased. John began to secretly frequent gay bars to meet gay men. On a number of occasions, he had sex with these men, but only after first getting drunk. He dated one man for 6 months. However, this man left him because of John's alcohol abuse and because he was still in the closet. John's alcohol abuse and his shame about his homosexuality have deeply affected his emotional well-being and all aspects of his life. John recently separated from his wife. He arrived in treatment stating he knows he is gay, but because he still has difficulty accepting himself, he engages in substance abuse to hide his pain.

Suggested Interventions

It is important for the counselor to assure John that he is safe to share his story and his pain. John needs validation that, in spite of his parents' good intentions, it was inappropriate to "cure him of his homosexuality." John is likely to be too vulnerable to share his pain in a group setting at this time. John needs the opportunity to discuss, in individual counseling sessions, the prejudice and pain he has endured and how it is related to his substance abuse. Although only the beginning of John's healing, it should not be ignored. It is a critical part of his therapy in early sobriety. Because John is at high risk for relapse while his self-esteem and self-acceptance are low, the counselor can assist John when he senses the time is right by identifying gay Alcoholics Anonymous meetings as one means to help John meet gay people who accept themselves. The counselor can also help by referring John to a therapist after he finishes treatment so that he can continue working on issues of self-acceptance.

SECTION III:
PROGRAM
ADMINISTRATOR'S GUIDE

Chapter 14 Policies and Procedures

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What providers will learn from this chapter:

- Administrative policies and procedures for serving LGBT clients in the following areas:
  - Organizational mission
  - Outreach and promotional materials
  - Advertising and public relations
  - Community relations
  - Administrative
  - Personnel
  - Staff training
  - Program design and implementation
  - Aftercare

Introduction

This chapter addresses the specific administrative policies and procedures that need to be implemented to help ensure that the infrastructure of the program is sensitive to and culturally competent with lesbian, gay, bisexual, and transgender (LGBT) clients. Administrators should understand that in order to provide effective recovery services to LGBT individuals, all aspects of a program should be examined for overt and covert expressions and perceptions of heterosexual bias—from outreach (including public relations) to aftercare services. A commitment should be made at every level of the program, from the board of directors to the direct line staff, to design and deliver services in a manner sensitive to the needs of LGBT individuals.

A program committed to serving LGBT clients should first demonstrate its commitment in written administrative policies and procedures. When implemented, these policies and procedures will help ensure that the delivery of fair and equitable clinical services is built into the fabric of the organization and does not depend only on personal commitment by staff members. These policies and procedures need to be comprehensive and permeate the entire continuum of care and all agency activities.

Strategies and Recommendations

Suggested administrative policies are described below for an agency's mission, treatment programming, promotional

material, advertising and public relations, personnel, training, and aftercare services. These suggestions are not intended to be definitive; they merely provide a foundation on which organizations can base programs and policy changes. Every policy and procedure needs to be tailored to meet the specific needs of the agency and to consider the type of services (i.e., modality) being delivered and geographic area (i.e., urban or rural).

Organizational Mission

Because LGBT communities are underserved and often invisible, it is important that treatment providers make a commitment to serving this population and incorporate it into the organization's mission statement, philosophy, and service literature.

Administrators should check and edit the mission philosophy or service statement to ensure it includes a commitment to serve LGBT communities.

Policies and Procedures Regarding Outreach and Promotional Materials

Consideration of the following points is critical when preparing promotional materials to distribute to potential clients, the community at large, and policymaking and funding sources.

- Ensure that promotional materials include information about LGBT-specific services, if appropriate.
- Use language that specifically identifies LGBT individuals as people the program is attempting to reach.
- Include images in promotional materials that depict individuals identifiable as LGBT individuals.
- Enlist the assistance of focus groups composed of a culturally diverse selection of LGBT individuals in the development of promotional materials for your agency.

Advertising and Public Relations Policies and Procedures

The following points are often overlooked in the promotional activities of mainstream substance abuse treatment organizations. Note that messages that reach LGBT individuals through mainstream media can be especially powerful.

- Advertise programs and events in LGBT periodicals as well as in the mainstream press and those publications that are geared to particular cultural communities.
- Create LGBT-sensitive public service announcements (PSAs) about your services for radio and television. Lobby the stations to carry the PSAs by personally meeting with the public service director.
- When producing cable TV programs on drug addiction and recovery for distribution to local public access cable stations, include LGBT clients and staff.
- Include articles by and about recovering LGBT individuals in newsletters.
- Submit articles about substance abuse issues in LGBT communities to LGBT periodicals as well as to the mainstream press and those publications that are geared to particular cultural communities.

Community Relations Policies and Procedures

Following are some suggestions for developing a seamless plan of communication and support between mainstream substance abuse treatment centers and LGBT communities.

- Provide speakers on substance abuse issues to LGBT organizations.

- Encourage staff to join boards, task forces, and commissions that advocate for empowerment on behalf of LGBT clients.

- Support LGBT-specific events in the community (dances, readings by LGBT writers, theater and music performances, and LGBT pride marches) through sponsorship, staff support, advertising, and distribution of announcements or by cosponsoring such events with LGBT communities.

- Form relationships with local LGBT and women's bookstores; provide space for them to sell books at events held at your agency.

- Provide an information booth at LGBT street fairs, as well as at events geared to specific cultural communities.

- Sponsor drug- and alcohol-free social events and sporting activities for LGBT individuals.

- Enlist the help of recovering LGBT substance abusers who might be willing to serve as mentors or sponsors for LGBT clients in your treatment facility.

- Help advocates for LGBT substance abuse services be represented on local, State, and Federal planning and policy boards.

Administrative Policies and Procedures

Instituting the following policies and procedures helps create a climate that ensures LGBT clients do not experience or perceive discriminatory practices or harassment.

- Create or confirm the existence of agency policies regarding freedom from discrimination and harassment based on sexual orientation, gender, and cultural background.

- Create procedures for filing complaints and a process for resolving reported violations of these policies.

- Ensure the enforcement of these policies at every level of the program, from the board of directors to the direct line staff, in such a way that individuals filing reports are not traumatized further.

- Investigate every complaint of discriminatory practices reported by LGBT clients and their family members.

- Ensure that all personnel from the board of directors to volunteers are trained, on a regular basis, on antidiscriminatory policies. Training should be experiential as well as didactic and include discussions of subtle forms of discrimination and harassment as well as blatant forms of this behavior. Ensure that all personnel are familiar with the procedures for reporting violations.

- Review all operational procedures, from initial phone contact through the intake process, to ensure that heterosexual bias has been eradicated and inclusive terms are available as options.

- Use the phrase "clean and sober" as opposed to "straight" to refer to individuals who are drug-free, since straight is often used to refer to individuals who are heterosexual.

Personnel Policies and Procedures

Inclusion of the following policies and procedures in agency operations will help ensure a nondiscriminatory environment for both clients and staff as well as equal representation of LGBT viewpoints in program and policy development.

- Include sexual orientation and gender identity in your nondiscriminatory employment policy.

- Develop and implement grievance procedures for employee reports or

complaints of discrimination based on sexual orientation or gender identity.

- Enlist openly LGBT members to serve on the board of directors and in other leadership positions. Ensure that LGBT individuals of color are represented in proportions that reflect the community demographics.

- Include partners in the definition of family when writing bereavement policies or sick leave policies on caring for family members.

- Ensure that the organization has a contagious-disease policy that includes HIV/AIDS (as opposed to an AIDS policy).

- Employ openly LGBT individuals as staff and consultants.

- Advertise job openings in LGBT publications.

- Establish an LGBT advisory board to help with program design, services, and community outreach to advise the board of directors, administration, and staff.

- Review the ability of staff to be inclusive and supportive; directly confront overt discrimination. Hold staff and leaders accountable for upholding the policies as set forth. The degree to which this performance goal is or is not met should be reflected in promotions and merit salary increases.

Staff Training Policies and Procedures

Establishing the following policies and procedures will ensure that new and incumbent staff are aware of the agency's LGBT-supportive stance on an ongoing basis.

- Ensure that all new employees are familiar with agency policies regarding hiring of and providing services to LGBT clients.

- As a part of regular staff training, include such topics as "LGBT cultures and communities."

- Ensure that staff members are allowed to explore their fears and prejudices in a non-threatening environment.

- Have up-to-date national and local listings of resources and services available within LGBT communities and have them in offices and waiting rooms for easy access by clients and staff members.

- Organize cross-training between local LGBT and community groups and your agency. Exchange information about substance abuse and recovery services for information about the LGBT community and its resources.

Program Design and Implementation Policies

Implementation of the following program design and implementation policies will help ensure that adequate resources are directed toward meaningful activities for LGBT clients from diverse backgrounds.

- Ensure that child care services are designed to include LGBT parents. Design workshops on parenting that are not biased toward heterosexuals.

- Utilize focus groups of recovering LGBT individuals in designing and expanding services to ensure the services meet the specific needs of LGBT clients.

- Ensure that case conferencing and clinical supervision address any issues raised in treatment by LGBT clients.

- Provide education for heterosexual clients about language and behaviors that show

bias toward LGBT people. Establish firm guidelines regarding client behavior, and consistently enforce these guidelines to ensure a treatment atmosphere of safety for LGBT (and all) clients.

- Emphasize and enforce the confidentiality of all treatment services and printed materials at staff trainings and all client functions.
- Make all family services available for the domestic partners and significant others of LGBT clients in your program. These may include conjoint therapy, family therapy, or groups.
- Be sure there are social events and activities appropriate and relevant to LGBT clients of diverse cultural backgrounds.
- Create opportunities for LGBT clients to attend workshops or meetings (including 12-step meetings) that are culturally specific. This can be done in conjunction with local LGBT program resources. Provide transportation for your LGBT clients to these events.
- Make sufficient financial commitment and invest adequate resources to allow your program to fully implement these policies and procedures.

Aftercare Policies and Procedures

Aftercare is critical for any client being discharged from a substance abuse treatment program. Establishing the following policies and procedures will help ensure adequate postdischarge care for LGBT clients.

- Identify a contact person who is an openly LGBT staff member and who will be available to LGBT graduates if they face any recovery crisis after discharge.
- Establish training procedures in which all staff members are educated about issues LGBT individuals face upon discharge. Include workshops on relapse triggers specific to LGBT individuals in recovery.
- Ensure that discharge procedures help LGBT clients develop relapse prevention strategies for high-risk situations specific to them, such as reentering bar-oriented LGBT communities, coming out to their family of origin if they decide to do so, and dealing with homophobia, discrimination, and/or gay bashing.
- Ensure that discharge procedures include providing each LGBT client with a comprehensive list of LGBT-specific and/or LGBT-sensitive community resources and services, along with clear information about how to access these services.

Following is a case example of a large, California-based mainstream substance abuse treatment program that has implemented specific policies and procedures for serving LGBT clients. The coauthors appreciate the efforts of Dr. Brian Greenberg and Ms. Christine Lanieri in providing this information.

Case Example

Walden House, Inc., is a large, nonprofit organization providing substance abuse rehabilitation services in San Francisco and the greater California community. Founded in 1969, Walden House has grown and thrived within the culturally diverse San Francisco environment. The agency now provides services to more than 3,500 individuals each year in its residential and outpatient programs. Approximately 20 percent of the clients in Walden House's main city-funded programs fall into the categories of lesbian, gay, bisexual, and transgender (LGBT). In its Ryan White CARE Act programs serving individuals with HIV/AIDS as well as substance abuse issues, more than half the clients are LGBT.

San Francisco is a nationally recognized Mecca for members of LGBT communities. The city's cultural diversity and progressive politics provide opportunities for real advances in LGBT rights. Gay and lesbian elected officials are a powerful force in local politics. LGBT people are actively involved in the local decisionmaking process regarding substance abuse, human services, and public health funding. The city actively prosecutes hate crimes, and many local businesses recognize the LGBT community through domestic partner initiatives, specific marketing campaigns, and sponsorship of events.

Recognition of LGBT lifestyles, values, and families is part and parcel of the fabric of the Walden House work and treatment community. The agency's commitment to cultural competency for LGBT clients is demonstrated through a number of administrative, clinical, and business policies and practices. The Board of Directors includes openly gay and lesbian members. Staff members who are LGBT are frequently open about their sexual orientation, and the agency ratio of LGBT staff to LGBT clients is two to one.

As a therapeutic community, Walden House promotes an atmosphere of acceptance and celebration of all cultures represented in the treatment environment. There is no tolerance within the Walden House community for discrimination, including homophobia, transphobia, racism, sexism, or any other discriminatory practice. LGBT people are included in the agency nondiscrimination statement and mission statement. Walden House offered domestic partnership benefits to staff even before the city of San Francisco mandated it for county contractors. Agency outreach literature describes services offered to these and other specific populations. Articles in the *Walden House Journal* have profiled "out" clients, staff, and board members. Staff members on the Walden House Special Populations Task Force help ensure cultural competency for LGBT clients. An agency representative serves on the San Francisco city and county LGBT Task Force. Data are collected on the number of LGBT persons served, and evaluation of the efficacy of treatment for LGBT populations is conducted on a regular basis.

In the treatment milieu, the special needs of LGBT clients are considered in the overall assessment process. LGBT clinical support groups are held bimonthly and are open to persons who are either LGBT or questioning their sexual identity. Therapists, counselors, and managers who openly identify themselves as LGBT are employed throughout the agency. LGBT clinical specialists are frequently included in the treatment planning team for LGBT clients. The client grievance procedure provides an avenue for addressing any perceived or actual wrong experienced by participants. Clients have the right to have representatives of their own choice at grievance hearings, and if LGBT issues are raised, an LGBT staff member is often made available to hear the grievance with other appropriate staff.

An example of Walden House's active involvement in the LGBT community is its participation in the Annual San Francisco Gay, Lesbian, Bisexual and Transgender Pride Parade. Walden House clients volunteer to collect donations, staff an information table, sell beverages, and have a float and large contingent in the parade. The event caps Pride Month, during which clients participate in special educational and recreational events. Heterosexual clients and staff participate in these activities as well.

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In developing this publication, several conversations were held with representatives of Inter-Care, a New York City-based private for-profit substance abuse treatment program. Inter-Care has gained a reputation in the LGBT community for safe and effective treatment by implementing many of the policies and procedures recommended in this chapter. Its steps included modifying history/intake/assessment forms to include LGBT-relevant issues, displaying LGBT-positive posters and reading materials at the clinic, providing staff training on issues of importance to LGBT individuals, and aggressive marketing of the program in the community. Inter-Care's efforts resulted in a fivefold increase in LGBT clients. Andrew Cicchetti, the former director of the Inter-Care LGBT program, is available as a resource and can be reached at

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New York, New York 10010
212–505–6212
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Chapter 15 Training and Education

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What providers will learn from this chapter:

- Training and educational issues related to serving LGBT clients
- Strategies and action steps for implementing training
- Essential LGBT-specific educational experiences for improving competencies of professionals and support staff

Introduction

This chapter presents an introduction to implementing the changes necessary to create an LGBT-sensitive substance abuse treatment environment, while at the same time improving the quality of training and education programs for substance abuse treatment practitioners and auxiliary staff. Administrators have a responsibility to ensure that all staff, not only clinicians, receive training and education to improve their sensitivity toward all individuals. Working to eliminate discrimination, both overt and covert, should be an ongoing activity.

As lesbian, gay, bisexual, and transgender (LGBT) individuals become more accepted and visible, they are seeking culturally sensitive, if not culturally specific, substance abuse treatment services. To help develop LGBT-sensitive care, providers can find competent care standards in the Center for Substance Abuse Treatment (CSAT) Technical Assistance Publication #21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (1998b), and in the 1999 CSAT publication, *Cultural Issues in Substance Abuse Treatment* (1999b).

Training and education programs seek to improve understanding of the complex issues with which LGBT individuals struggle. To support the diverse LGBT population, educators, administrators, substance abuse treatment professionals, nurses, clinical supervisors, students, other professionals,

and local communities all should be considered in the educational process.

A holistic approach to treatment is most likely to enable LGBT individuals to effect real change in their lives. Therefore, a **multifaceted** approach is suggested to improve the present situation, wherein treatment professionals and society have incomplete and inadequate information that often leads to a misunderstanding of LGBT issues and even a denial that LGBT individuals have special needs.

Substance abuse treatment professional training programs, faculties, institutions, administrators, health care "gatekeepers," and community settings all require education and training. Targeting certain community dimensions is crucial to the success of a training or education program.

Issues To Consider

The following information could be included in a training or educational program.

Barriers to Treatment Access

Barriers to adequate substance abuse treatment for the LGBT community have been touched on in other chapters. In addition to the reasons any prospective client might have, the reasons LGBT individuals may avoid or delay seeking professional care include fear of disclosing their sexual orientation or gender and previous experiences with health care providers who attempted to convert them to heterosexuality, who attributed their substance abuse to their sexual or gender orientation, or who were otherwise judgmental and unsupportive.

Engagement and Retention

LGBT individuals may leave treatment prematurely for the same reasons as non-LGBT clients. But LGBT clients may have additional treatment difficulties if a facility lacks culturally specific services, if it lacks self-identified LGBT practitioners or sensitive counselors, if it has few contacts with the non-substance-abusing LGBT community, or if it fails to engage non-LGBT clients in exploring their prejudices or honoring diversity.

Relapse Prevention

While many programs address relapse prevention, LGBT clients may need additional help to find LGBT-specific resources, which may be scarce outside metropolitan areas. LGBT clients may have difficulty addressing problems with their sexual or gender orientation and may have difficulty with their families of origin, complications related to other addictive behaviors, and issues related to HIV/AIDS, such as grief and loss or medication compliance. Additional counseling referrals for these issues may be required.

Lacking specific and often essential information about the special problems of LGBT clients, professionals may attribute treatment failures to the clientele rather than to the insufficient training and education about LGBT issues that resulted in inappropriate treatment by the providers.

Strategies

An integrated training and education system addresses both content and process and uses experiential as well as didactic methods. It addresses six components:

- Trainees
- Faculty or trainers
- Program
- Institutional systems
- Professional peers
- Community.

Improving present treatment conditions for LGBT clients requires a comprehensive training approach that includes the six

components. Long-term results are more likely with an approach that addresses these components. The process of implementing training and program change begins with a commitment to action by decisionmakers.

The intention of training and continuing education is to increase the sensitivity and competence of the staff and, ultimately, to improve treatment outcomes. The learning objectives are to:

- Raise awareness of culturally specific issues and the sensitivity of all involved persons
- Identify and become fluent in LGBT-appropriate and sensitive language
- Implement explicit nondiscrimination policies and procedures
- Develop skills to support LGBT individuals in substance abuse treatment services
- Compile a resource list of local, regional, and national support services.

Training should at least result in LGBT-tolerant treatment. Beyond that, however, training can help practitioners help their clients be more comfortable with themselves and their lives. In gender-specific treatment, services should include attention to LGBT issues. Assuming that the separation of men and women will enable practitioners to address LGBT needs is false. Treatment that is LGBT antagonistic should be changed but with the realization that great effort and patience will be required.

Program content should be specifically shaped by the target audience's understanding of LGBT issues.

Addressing the Six Components Effectively

Component 1: Trainees

Trainees include behavioral health professionals; licensed and/or certified counselors; students enrolled in counseling education programs; conference and seminar attendees; staff at inservice training; primary, secondary, and tertiary caregivers; staff of health maintenance organizations (HMOs); case managers; primary care physicians; probation officers; and so forth.

Action Steps

- Recruit and select LGBT individuals of diverse ethnicity for counselor education programs and work settings.
- Develop students' awareness of the need to understand LGBT issues.
- Provide counseling and other appropriate measures for students struggling with their own homophobia or negative attitudes toward LGBT persons.

Component 2: Faculty or Trainers

The faculty or trainers are members of counseling and social work departments responsible for curriculum development, course delivery, and practicum supervision. They prepare professionals and support staff for the behavioral health professions and provide training at seminars and workshops as well.

Action Steps

- Develop faculty and agency awareness of the need for improved understanding of LGBT issues.
- Attain and maintain a diverse faculty with theoretical and practical expertise in LGBT treatment and care.

- Recruit LGBT faculty and staff who can provide instruction, supervision, and services.
- Encourage and support all faculty and staff to continue their education in LGBT treatment areas.
- Support faculty and staff research in LGBT treatment.
- Assign decisionmaking roles to faculty who are knowledgeable about LGBT issues.

Component 3: Program

Managed care organizations, consumers, and quality improvement measures demand that health care be evidence based. Therefore, any training or educational program needs to be based on current research findings. Training elements should include assessment of need, attitudinal behavior changes, skills training, methods development, training and education program evaluation, and actions to implement change.

Action Steps

- Conduct an assessment of the current level of tolerance, sensitivity, and affirmation of the treatment agency staff.
- Gather and review pertinent research and theoretical material.
- Recruit skilled professionals as trainers and educators, and/or develop an interagency training alliance.
- Develop program materials and methods that are site- or client-specific.
- Determine methods for evaluating the effectiveness of the training or educational program.

Attitudinal Behavior Changes and Skills Training

- Utilize experiential exercises that uncover hidden biases in a safe manner (e.g., roleplay a 21-year-old coming out to his parent or ask participants to introduce themselves as lesbian, gay, bisexual, or transgender individuals).
- Encourage exploration of stereotypes and language, values, and behavior differences.
- Use various methods incorporating adult learning styles to increase skill development.
- Use additional resources available on videos and films.

Methods Development

- Make LGBT sensitivity and competency training a priority in the basic curriculum or in the inservice training schedule—an important first step in implementing this type of program.
- Redesign existing programs to include LGBT-related competencies. Use a team approach involving academic and clinical staff and, if possible, a team member from the LGBT community at large.
- Develop courses awarding continuing education units (for academic and/or professional credit) for professionals and support staff.

Evaluation

- Give pretests and posttests to evaluate training.
- If possible, make videotapes or audiotapes of clinical sessions before and after training to ascertain whether there have been changes in the ability to treat LGBT clients.

- Collect client satisfaction and followup data from LGBT clients treated at the same site over time.

- Conduct quality improvement studies focusing on the effects of LGBT sensitivity and competency training.

Component 4: Institutional Systems

For the purpose of this volume, the phrase "institutional or agency systems" refers to the individuals who serve as gatekeepers: administrators of organizations, departments, and schools who are responsible for the delivery of programs and services; boards of directors; and other staff.

Action Steps

- Gain administrative awareness of the need for improved understanding of LGBT issues.

- Create an administrative environment supporting LGBT care, treatment, and confidentiality.

- Require LGBT competency and sensitivity at all levels, including policy development.

- Institutionalize a policy for ongoing recruitment and selection of LGBT administrative, professional, and support staff.

- Encourage and support the use of LGBT staff and faculty to provide instruction and supervision.

- Institute administrative and clinical policies to endorse LGBT sensitivity and competency training, LGBT treatment, and unbiased care.

- Allocate curriculums, time, and resources for training.

Component 5: Professional Peers

Effective techniques for training and skills development and "what works" often are the subject of consultations among professionals. This important dimension of the training process plays a significant role in introducing important ideas to newcomers and improving practice by long-term practitioners as well.

Action Steps

- Increase professional peers' awareness of the need for improved understanding of LGBT issues.

- Articulate the need for implementing programs at all levels of practice in professional associations.

- Convene conferences about LGBT treatment.

- Involve LGBT professionals in policymaking.

Component 6: Community

The family, neighborhood, town, city, State, and region in which LGBT clients are treated is their "home." The response of the community to LGBT clients is a crucial factor in their care and treatment.

Action Steps

- Provide counseling services to the families of LGBT clients at all socioeconomic levels.

- Provide information on treatment and the special needs of LGBT clients to relevant parties in the community: government officials, police, and all criminal justice professionals.

- Create task forces to work directly with LGBT interest groups.

A Training Model

The State of New York designed a model curriculum program detailed in *Working With Lesbian, Gay, Bisexual and Transgender Clients in Alcoholism and Substance Abuse Services: Trainers Manual*, (New York State Office of Alcoholism and Substance Abuse Services, Academy of Addiction Studies, 1996). This manual presents a core curriculum and specific modules for both theory and skill competency. The curriculum includes information on the need to raise consciousness about LGBT clients, stereotyping, myths, homophobia, and terminology. An example of the resources included in it is shown in exhibit 15–1, the Cass Model of Lesbian and Gay Identity Development. This model can be especially helpful for substance abuse treatment practitioners who are treating LGBT clients and who want to understand the stages their clients may be in or moving through. This kind of understanding will help practitioners provide more sensitive and effective treatment. Other resources in the curriculum are the Kinsey Scale, the Fifield study, the McKirnan and Peterson study, and organizational development tools that address diversity in the workplace and homophobia/heterosexism assessment surveys.

To receive this curriculum call or write to:

Office of Gay and Lesbian Health Concerns
125 Worth Street, Suite 601
Box 67
New York, NY 10013
212–788–4310
or
Community Health Project
208 West 13th Street, Second Floor
New York, NY 10011
212–675–3559

Exhibit 15–1:
Cass Model of Lesbian and Gay Identity Development

Stage I: Identity Confusion
Occurs when a person begins to realize that he or she may relate to and/or identify with being gay or lesbian; a process of personalizing the identity.
Tasks: *Exploration and increasing awareness*
Feelings: *Anxiety, confusion*
Defenses: *Denial*
Recovery: *Having a confidential support person*

Stage II: Identity Comparison
Occurs when a person accepts the possibility that he or she might be gay or lesbian.
Tasks: *Exploration of implications, encountering others like oneself*
Feelings: *Anxiety, excitement*
Defenses: *Bargaining and rationalizing*
Recovery: *Meeting gays and lesbians in recovery*

Stage III: Identity Tolerance
Occurs when a person comes to accept the probability that he or she is gay or lesbian.
Tasks: *Recognizing one's social and emotional needs as a gay man or lesbian*
Feelings: *Anger, excitement*
Defenses: *Reactivity*
Recovery: *How to be gay or lesbian and stay sober*

Stage IV: Identity Acceptance
Occurs when a person fully accepts rather than tolerates being gay or lesbian.
Tasks: *Development of community and acculturation*
Feelings: *Rage, sadness*
Defenses: *Hostility toward straight culture*
Recovery: *Lesbian and gay recovering community building*

Stage V: Identity Pride
Occurs when a person immerses himself or herself in the lesbian and gay community and culture to live out his or her identity.
Tasks: *Fully experiencing being gay or lesbian, confronting internalized homophobia*
Feelings: *Excitement, focused anger*
Defenses: *Arrogant pride and rejection of straight culture as the norm*
Recovery: *Sexuality, identity, and recovery*

Stage VI: Identity Synthesis
Occurs when a person develops a fully internalized and integrated lesbian or gay identity and experiences himself or herself as whole when interacting with others in every environment.
Tasks: *Coming out as fully as possible; having an intimate gay or lesbian relationship; self-actualization as a gay man or lesbian*
Feelings: *Excitement, happiness*
Defenses: *Minimal*
Recovery: *Maintenance (end stage)*

Adapted from Cass, 1979

Chapter 16 Quality Improvement and LGBT Clients

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What providers will learn from this chapter:

- How leaders determine whether quality assurance efforts are needed
- Specific questions that help define quality in providing treatment to LGBT clients
- How leaders monitor and assess efforts to improve quality

Introduction

This chapter offers suggestions on how to incorporate an evaluation of substance abuse treatment services for lesbian, gay, bisexual, and transgender (LGBT) clients into an agency's quality improvement program. It will help leaders create questions and monitor responses about the issues and recommendations raised throughout this volume.

The conceptual framework common to all quality improvement programs includes the following steps:

- Define quality in terms of concrete functional processes and outcomes that can be assessed
- Implement some means of measuring such processes and outcomes
- Evaluate the data over time with respect to goals and/or external benchmarks
- Analyze the factors and processes that impact performance
- Identify priorities for improvement
- Make process and procedural changes as appropriate
- Continuously monitor the effects of these changes.

A Framework for Functionally Defining Quality

Because any discussion on the quality of care provided for LGBT communities is, by necessity, a discussion of cultural competence, quality indicators should be functional measures of this competence.

The central mission of accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), and the Commission on the Accreditation of Rehabilitation Facilities (CARF) is to establish standards for what they consider the key functions of substance abuse treatment centers and indeed all health care organizations. These standards provide frameworks for quality improvement that can be adapted to the specific task of improving service to LGBT individuals. In addition to ensuring a comprehensive approach, the use of standards provides the added bonus of assisting the organization during external surveys and reviews.

The outline that follows shows how JCAHO standards can be used to address quality improvement with respect to service to LGBT individuals. Standards developed by NCQA or CARF could be used similarly. Adapting the standards is fairly straightforward. For example, standards for leadership are directed at how well an organization plans, structures, and delivers its services to meet the needs of its users, who are defined by the demographics of people in the service area. This means that the organization should both know about and appropriately serve LGBT individuals within its service area.

Leadership

- Do needs assessment and planning activities include LGBT clients in the community? Is their inclusion proportional to the percentage of the population they represent?
- How does the organization design services to meet the needs of the LGBT community, and how well are these services delivered?
- How effectively does leadership identify and cultivate community resources for LGBT clients?

Human Resources

- How does the organization measure and improve the competency of its staff in serving LGBT clients?
- What kinds of educational and training activities address these competencies?

Patient Rights and Organizational Ethics

- Are LGBT clients' cultural, psychosocial, spiritual, and personal values respected?
- Do LGBT clients' significant others or support people participate in care decisions?
- Do LGBT clients receive information about their condition that recognizes their special circumstances and helps them make informed decisions?
- Do policies and procedures for LGBT clients address circumstances in which care will not be given because their condition or lifestyle conflicts with staff members' values, ethics, or religious beliefs?
- How are privacy rights of LGBT clients protected?

Education of Patients and Families

- Are educational materials appropriate and relevant for LGBT clients?

- Are educational programs accessible to LGBT clients' significant others and support people?

Assessment of Patients

- Are relevant medical issues and social issues effectively and comfortably identified for LGBT clients?

Care of Patients and Continuum of Care

- How do care plans demonstrate sensitivity to the needs of LGBT individuals?

- Do discharge plans take into account the lifestyles and personal support systems of LGBT clients?

Management of Information

- Is the information system set up to collect data important to LGBT clients?

- Do assessments of information requirements include the special needs of LGBT clients, the providers serving them, and other service agencies?

- Does the information system facilitate tracking performance and outcome data for the LGBT client base?

Performance Improvement

- Do aspects of the performance improvement plan include specific monitors of and quality improvement activities aimed at services for LGBT clients?

Collecting Baseline Data

Quality improvement programs measure performance against baseline data. This means adding appropriate data fields for recording one's transgender identity, sexual behavior or identity, and information about significant same-sex relationships to forms used to collect client demographic data. Coding this information will require programs to respect consumers' wishes about confidentiality but also provide information on one's sexual orientation and gender differences, issues, and concerns.

Many people feel that this is personal information, that asking about it is awkward and inappropriate, and/or that people's right to privacy must be protected. Providers should be mindful that the guiding rationale for collecting sexual orientation and transgender identity information is to determine whether these communities are being properly served and what health problems they are experiencing. On this last point, confidentiality should always be of concern. Clients can never be forced to provide **any** demographic information, but policies to preserve privacy rights should not keep people from communicating and recording their sexual orientation or transgender identity if they choose to do so.

The ability to elicit baseline demographic data about their LGBT client population is an important measure of competency for LGBT care providers. Many, if not most, staff members will need formal training on how to ask the necessary questions. Training relating to collecting this information will need to consider a variety of factors (e.g., age, culture, ethnicity, and individual consumer differences). Self-administered questionnaires could be used. By providing a blank space where they can identify their gender if they choose, the items on such questionnaires can be posed to clients so it is not necessary for them to commit to being either male or female. Eli Coleman's assessment tool (1987) shown in chapter 1 is an example of an effective form. It will be important to explore how to collect these data later in the treatment episode if they are not volunteered at intake or during assessment.

The initial staff training on data collection will provide agency leadership with an important gauge of the attitudes and comfort level of staff working with LGBT clients. The close attention and expressed commitment of leadership is, therefore, of critical importance. Because staff competency and comfort are important, baseline data on this issue should be collected at the start of training and throughout training/performance improvement efforts.

Once baseline information is gathered, the percentage of LGBT clients using the facility should be compared to the best available estimates of the percentage of LGBT individuals in the community at large. Comparing the two numbers will provide important information on how well the facility is meeting LGBT clients' needs. Even if the proportion of LGBT clients matches or exceeds the proportion of LGBT individuals in the community at large, there may be considerable room for improvement in working with LGBT individuals considering that clients may hide their identities because of lack of support or fear of persecution, especially in areas where there is no visible LGBT community. Ironically, those who are uncertain about disclosures or reluctant to disclose that they are (or might be) LGBT individuals may likely require the most support concerning these issues.

The key questions that every program should address are:

- How well does the program or staff elicit information regarding clients' sexuality? Is the atmosphere uncomfortable?
- Are LGBT outreach efforts effective?
- Are there actual disincentives for such clients to seek care at the center?

Monitoring Progress

A variety of means can be used to monitor progress with respect to quality improvement goals.

Client feedback is a very valuable source of information in the initial assessment phase of the project, in monitoring progress, in identifying specific areas that need improvement, and in soliciting suggestions on how improvements could be made. **Client satisfaction surveys** can include questions to assess the LGBT friendliness and competence of the staff and facility. Questions can be indirectly worded, as seen in the sample survey form (exhibit 16–1).

Another tool that might prove useful is the **guest client**—a volunteer who visits the facility, uses some aspect of care, and then reports his or her experiences. Guest client activities can range from a simple phone call for information to completing a formal intake. Participation in group therapy is probably not appropriate. It is important to inform staff that such a program is being implemented and present it as a way of gathering information rather than as a way of checking up on people. If the agency is unable to find appropriate volunteers, seek assistance from local LGBT social service agencies or other organizations.

Exit interviews and **patient satisfaction interviews** are also excellent ways to obtain direct feedback and solicit suggestions. All clients should be asked routinely to participate in these interviews, not just openly gay, lesbian, transgender, or bisexual clients. Questions on the staff's comfort with issues pertinent to gender or sexual activity should be posed to **all** clients and in such a way that the sexual orientation of the client is not an issue. The interviews should also include questions to assess the staff's comfort with LGBT issues. This can be their last opportunity to communicate acceptance and willingness to discuss LGBT concerns. It should be made clear to clients that refusal to participate will not affect treatment in any way and that any comments will be kept in the strictest confidence.

Exhibit 16–1:
Client Satisfaction Survey

Today's Date:_____

Please do not identify yourself. This is an anonymous survey. No individual person or information regarding a specific event will be identified. Declining to complete this survey in no way affects the services and care you receive.

- Did you feel comfortable discussing sexuality issues with your therapist?

  ☐ Very comfortable
  ☐ Somewhat comfortable
  ☐ Somewhat uncomfortable
  ☐ Very uncomfortable

- Did you feel comfortable discussing sexuality issues in therapy group?

  ☐ Very comfortable
  ☐ Somewhat comfortable
  ☐ Somewhat uncomfortable
  ☐ Very uncomfortable

- Did you feel that you could openly discuss your relationships and involve your significant other in treatment/discharge plans?

  ☐ Very comfortable
  ☐ Somewhat comfortable
  ☐ Somewhat uncomfortable
  ☐ Very uncomfortable

- Do you consider yourself

  ☐ Heterosexual
  ☐ Gay
  ☐ Lesbian
  ☐ Bisexual
  ☐ Transgender
  ☐ Unsure
  ☐ Questioning?

- Did you discuss your sexuality at any time with any of the following? Check all that apply:

  ☐ Therapist
  ☐ Other clinical staff
  ☐ Administrator
  ☐ Other clients

- With which individuals do you feel comfortable discussing any aspects of your personal life or sexuality?

  ☐ Therapist
  ☐ Other clinical staff
  ☐ Administrator
  ☐ Other clients

- Was your significant other acknowledged?

  ☐ Consistently and directly
  ☐ Occasionally or indirectly
  ☐ Not at all

Continued ⟶

Exhibit 16–1:
Client Satisfaction Survey (continued)

- Was your significant other included in treatment plans?

  ☐ Consistently and directly
  ☐ Occasionally or indirectly
  ☐ Not at all

- In general how comfortable are you in this facility with regard to your LGBT identity?

  ☐ Very comfortable
  ☐ Somewhat comfortable
  ☐ Somewhat uncomfortable
  ☐ Very uncomfortable

- How comfortable was your relationship with other clients with regard to your LGBT identity?

  ☐ Very comfortable
  ☐ Somewhat comfortable
  ☐ Somewhat uncomfortable
  ☐ Very uncomfortable

- If you are a transgender individual, did you feel your gender identity was acknowledged as you wished by

  - Therapist ☐ yes ☐ no
  - Other clinical staff ☐ yes ☐ no
  - Administrator ☐ yes ☐ no
  - Other clients ☐ yes ☐ no

- Did facilities such as inpatient rooms and bathrooms meet your needs? ☐ yes ☐ no

- How could we acknowledge your needs as an LGBT individual more effectively?

  _____

  _____

DEMOGRAPHICS:

Age Today: _____ Biological Sex: M☐ F☐

Race/Ethnicity: White _____ African American _____

Asian _____ (Specify ethnicity)_____

Pacific Islander ____ (Specify ethnicity)_____

American Indian____ (Specify ethnicity)_____

Hispanic____

Primary language spoken at home: ☐ English ☐ Spanish ☐ Other (Specify)_____

Adapted from Coleman, 1987

Additional strategies could include using **focus groups** run by staff or local advocacy organizations and examination of service utilization patterns to determine whether LGBT clients are missing appointments, dropping out early, or showing a high incidence of complaints and grievances.

Information from all of these sources should go regularly to the quality improvement committee and clinical and administrative leadership. As significant issues are identified, they should be incorporated into the agency's quality improvement strategies. Again, assistance from LGBT advocacy groups and other LGBT treatment programs will be valuable in addressing specific issues. As with any quality improvement effort, continuous reassessment of the available data or information is essential to maintaining positive ongoing results.

Evaluating Outcomes

Ultimately, the goal of quality improvement with respect to service to LGBT clients is to achieve better treatment outcomes. It is important to look at measures of treatment efficacy in the overall context of the number of LGBT clients in treatment. At this point, specific outcome measures can be evaluated. These include the following:

- Number of LGBT clients abstaining from substance use
- Number of LGBT clients relapsing
- Number of LGBT clients readmitted.

Outcomes for LGBT clients can be compared with outcomes in the agency's general client population. Although it may not be possible to do this in a statistically significant manner due to the relatively low number of LGBT clients or differences in case complexity, this comparison is a functional measure of how effective the agency's program is for LGBT clients and is useful if interpreted appropriately. Outcome data for LGBT clients can also be compared, over time, to baseline LGBT client participation rates to measure how quality improvement activities have impacted care. Finally, the agency's outcomes can be compared with outcomes of organizations that have well-established programs for LGBT clients. This last comparison may be useful in establishing realistic, yet appropriately ambitious, benchmarks and goals. Contact with other agencies may also help identify technical assistance and new practices and skills that might further enhance treatment quality.

Case Example

XYZ Hospital is a comprehensive substance abuse treatment program in a large metropolitan area. The program includes a 125-bed inpatient unit, an intensive outpatient program, and a day hospital program.

The facility is located in one of the city's most densely populated gay and lesbian areas. Its leaders gained awareness of the community by reading local area newspapers, noting gay-oriented businesses, and through self-identified LGBT staff and clients. It was principally gathering information through exit interviews with clients and regularly assessing the volume of LGBT clients served relative to the service area. Based on these assessments, three goals were set: (1) improving the comfort level of clients in groups; (2) helping clients feel more comfortable disclosing their identities; and (3) attracting more LGBT clients to the program. At the time of the initial evaluation, there were two or three openly gay or lesbian clients in each of the program components.

Around this time, the hospital was approached by a national gay- and lesbian-targeted substance abuse treatment program that wished to establish an LGBT-specific program at the hospital. Its leadership felt that the program would assist it in achieving its goals and chose to go forward.

Since the program began, there have been significant increases in the number of LGBT clients served. In the most recent survey, 10 of 90 inpatients, 6 of 20 intensive outpatients, and 10 of 60 day hospital patients identified themselves as LGBT individuals. A market survey revealed that the visibility of the program in the community has been greatly enhanced, and regular client satisfaction surveys reported that LGBT clients feel much more comfortable in treatment, particularly in group settings, and are more satisfied with hospital services overall.

The program currently monitors outcomes in terms of the number of readmissions within a set number of days, adherence to treatment plans, and the number of clients who drop out of treatment. Staff members compare data on LGBT clients with data on clients in the general population cautiously, because LGBT clients have been shown to be at much higher risk and have more complicating factors than clients from the population at large. Staff members are trying to find other ways to compare data and are using outside resources to help them adjust risk factors for better data interpretation.

Chapter 17 Using Alliances and Networks To Improve Treatment for Lesbian, Gay, Bisexual, and Transgender Clients

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What providers will learn from this chapter:

- The rationale for alliance building among LGBT communities
- The essential elements of alliance building
- How managed care affects care for LGBT individuals
- How alliances and networks can be used to help with the financing and delivery of treatment services for LGBT individuals

Introduction

This chapter provides information about the rationale for alliance building between substance abuse treatment providers and the lesbian, gay, bisexual, and transgender (LGBT) community, the steps of alliance building, the impact of managed behavioral health care for LGBT individuals, components of effective alliances, and examples of LGBT provider networks.

Rationale for Alliance Building and First Steps

Providers who are moving into this service area typically do not have strong ties to LGBT communities or to service organizations that traditionally have provided services to these individuals. It will be important to build alliances both with the LGBT community and with organizations, service providers, and agencies in the community at large.

Once the decision has been made to introduce or strengthen treatment services for LGBT individuals, a small contingent should begin to enlist support among the targeted organizations—the public health groups, local health advisory committees, and other organizations that have a stake in improving substance abuse treatment for LGBT individuals. It is important that the

treatment facility not promote itself as LGBT sensitive or providing LGBT services until this important groundwork has begun and adequately trained staff members are in place.

The LGBT community is well schooled in working together and forming alliances. These alliances serve several important functions. They bring people together socially, provide a culture and ideology, accept same-gender orientations and behaviors, and validate lifestyles. Many LGBT communities, when addressing societal problems such as substance abuse or HIV/AIDS, recognize the value of establishing alliances with other groups. Alliance building has proved to be a powerful tool for LGBT community development (see Guinier, 1994; Vaid, 1995). Candidates for alliance building can be LGBT focused (e.g., the Human Rights Campaign) or non-LGBT focused (e.g., an HIV/AIDS organization, Alcoholics Anonymous, State and regional health departments, corporations, volunteer-based organizations, and universities). Some additional candidates for alliances are LGBT community centers (several hundred are located throughout the United States), LGBT social organizations (which frequently are important resources in suburban and rural areas), AIDS service organizations, and the many LGBT Alcoholics Anonymous chapters. Primary medical care providers who provide LGBT-sensitive services are also an important resource.

Some LGBT community organizations emphasize independence and work on the same issues in isolation, creating the potential for duplicating services. In the wake of managed care's influence on behavioral health care, better case management, networking of services, and mergers, many alliances have been formed in the past decade. Other organizations have gradually moved toward cooperation and help one another to accomplish mutually beneficial goals.

Alliances exist on a continuum of cooperation, ranging from loose referral relationships to formal coalitions with set organizational structures. Alliance building starts with recruitment of members and development of a mission and goals. A summary of the essentials of forming effective formal alliances and making them work is presented in exhibit 17–1.

It is important to emphasize to staff members and potential allies that creating a culturally responsive environment for LGBT clients is integral to providing a safe setting for all clients and to helping all people in recovery learn to live in a diverse society.

To build support for the alliance, identify possible organizations and individuals in the community who have a stake in reducing substance abuse in the LGBT communities. Designate alliance members to visit these potential participants. Some will need little persuasion, whereas others will require greater efforts. Inform potential members of the advantages of minimizing LGBT substance use. Solicit letters of support from a variety of key people in the community (e.g., politicians, religious and community leaders, health providers, business persons, legal organizations) who may convince hesitant members that broad-based support for addressing LGBT substance abuse treatment already exists.

The Impact of Managed Care on Behavioral Health and LGBT Individuals

By the end of 1995, the behavioral health care benefits of 142 million individuals were provided under managed care contracts (IOM [Institute of Medicine], 1997), and the number continues to grow. Both private and public health care purchasers are largely contracting with managed behavioral health care organizations (MBHCOs) (IOM, 1996, 1997) to organize specialized mental health and

Exhibit 17–1:
Forming Effective Alliances and Making Them Work

Recruitment

Seek support from a broad cross-section of the community. Contact key community leaders early in the process. The broader the coalition, the more effective it will be.

Encourage alliance members to view their decision to improve substance abuse treatment for LGBT people as an act of compassion and as a way to help in the recovery of all substance-abusing persons.

Use duplicate representation strategically because peers are greatly influenced by peers. For example, hospital administrators trust the opinions of other administrators, and counselors will sympathize with other counselors.

Persuade member organizations to designate a representative who has decisionmaking authority and attends meetings consistently. Involve top management, but not at the expense of leaving out lay persons and community workers in the LGBT communities.

Don't let the presence of professionals, or any one group, dominate the vision, agenda, and outcome of the alliance.

Decisionmaking

Identify a coordinator for large and complex alliances to facilitate meetings and the workings of the group. The coordinator should have expertise in interpersonal relations, negotiation, team-building, and group dynamics as well as the support of all alliance members.

Insist that there be no independent decisions without the endorsement of all alliance members.

Define a common mission and set collective goals. Consensus building is vital to alliance effectiveness.

Define consensus building as "Can you live with this?" and not as "Do you agree with this?"

Conflict Resolution

Be sure that each member appreciates the contributions of the others and acknowledges that each member has its own history, structure, and agenda. An established agency with a large budget and many members may contribute differently than does a young organization with a modest budget, few staff members, and limited membership; both types of contributions should be valued by alliance members.

Remember there may be a need to agree to disagree on some issues while staying focused on the common mission.

Use subcommittees to provide a forum for discussion of conflicts. They can then formulate recommendations for the alliance and present them at subsequent meetings (where emotions are kept at bay).

Insist that disagreements remain within the group and not be discussed in the community at large.

Publicity and Communications

Disseminate decisions made at alliance meetings throughout the community as well as to the boards, staff, and volunteers of the member organizations.

Credit all members of the alliance on your letterhead and in any publicity materials.

Continued

Exhibit 17-1:
Forming Effective Alliances and Making Them Work (continued)

Use a catchy name and logo. Publicity material should include the names of all member organizations.

Use community newsletters and local media to inform the community about the goals and progress of the alliance.

Distribute background information to demonstrate the need for substance abuse treatment for LGBT people.

Recognize potential opposition to the group's mission, and do not underestimate the impact of people with different opinions. A common misperception is that substance abuse treatment for LGBT clients promotes homosexuality or bisexuality. Respond by explaining that LGBT treatment is not about sex but about recovering from alcohol and drug abuse.

Anticipate opposition, and develop an alternative strategy that explains clearly the goals and activities of the alliance.

Use a variety of channels to disseminate information, including news conferences, news releases, letters to the editor, letters to legislators, and public endorsements from reputable community and professional groups.

Frame the discussion of LGBT substance abuse in easily understood terms and in a realistic cultural context.

Advocacy
Work both with and outside the government system in a coordinated fashion. Attend meetings with government officials, politicians, staff, and city councils in a small group while still maintaining broad representation. Interact with politicians on a nonpartisan basis, meet with all political parties, and utilize political affiliations of individual alliance members to gain access.

Remember that your goal in part is to educate others so they can advocate for your issues.

Before meeting with officials or politicians, research their positions on substance abuse treatment in the LGBT community. If they are opposed to improving treatment, try to gain their support. If they are sympathetic, enlist their support by asking for ways in which your alliance could help them accomplish the common goal. Be flexible; however, discuss any shifts in position with the alliance to gain its approval.

Always provide cogently written, brief, printed materials about the alliance's goal. Do not provide inaccurate, misleading, or self-serving information. Follow up with a letter of thanks and a summary of agreements or positions as you understand them.

Participation and Leadership
Ensure effective leadership to inspire member participation. Involvement can be improved if people feel that the alliance belongs to them and that their ideas and membership are valued.

Create a leadership development plan to increase the pool of experienced and skilled members who rotate through leadership positions so that the alliance can be sustainable and effective.

Insist that the leader delegate tasks so that participants know what needs to be done.

Case Example
Resource Center of Dallas: Alliance Building at Work

The Resource Center of Dallas (RCD), founded in 1983 in Dallas, Texas, is an excellent example of the power of alliance building within the LGBT community. It is a nonprofit corporation established by the Dallas Gay and Lesbian Alliance to promote understanding of sexual orientation and to study the effects of discrimination based on sexual orientation and their implications for public policy. As AIDS became an increasingly critical area of concern for the gay and lesbian community, RCD expanded its mission to encompass HIV, health, and substance use issues. To ensure communitywide support for its activities, it emphasized forging alliances with non-LGBT communities and with community agencies. Its board, staff, and volunteers believe in the importance of developing and maintaining alliances with those of other genders, sexual orientations, and ethnicities. More than 50 percent of its volunteers and board members are self-identified heterosexuals. There is a concerted effort to have gender and ethnic diversity at every level of the organization.

According to Jamie Schield, Co-Executive Director of RCD, the center has a history of alliance building with a wide array of organizations, ranging from those that are totally independent (resistant to alliance building), to those opting for a less formal arrangement (e.g., monthly luncheon meetings of area HIV/drug educators), to those favoring a formalized, structured alliance (e.g., the HIV Prevention Community Planning Coalition for Region III, Texas). To effectively reduce substance abuse and to promote health and wellness in the LGBT community, RCD is now creating alliances with others in the community. Schield emphasized that although "individuals or groups that are in alliance with RCD may not share similar values or perspectives, for they live, dress, recreate, and often see things very differently from RCD, it is precisely this difference in view that is most effective." The fact that RCD is working with others as a group to address the issue of substance abuse in the LGBT community, despite cultural and individual differences, resonates with the community, adding credibility to RCD's message. The Alliance's membership legitimizes the issue, and the public now perceives broad-based community support, effectively weakening RCD's opponents' ability to label RCD's efforts as those of "special interests."

RCD's alliance-building process involves both LGBT and non-LGBT community groups. They include representatives from the faith community (Cathedral of Hope—Metropolitan Community Church; Potter's House—Transformation Treatment Center), ethnic groups (African-American Health Coalition, Dallas Intertribal Center, La Sima Foundation), volunteer-based recovery programs (Alcoholics Anonymous), substance abuse treatment councils (Greater Dallas Council on Alcohol and Drug Abuse), emergency temporary shelters (Austin Street Shelter, Welcome House, Inc., Johnnie's Manor), drug intervention programs (Ethel Daniels Foundation, Inc., Oak Lawn Counseling Services), aftercare programs (Community Alcohol and Drug After Care Program, New Place, Inc.), public health programs (Dallas County Health and Human Services, Parkland Health & Hospital System), veterans' organizations (Veteran Affairs—North Texas Health Care System), and non-LGBT community groups (Parents, Families and Friends of Lesbians and Gays, PFLAG Dallas).

substance abuse treatment for enrollees independently from overall health care.

Purchasers, either private or public, contract with mental health and substance abuse treatment specialist organizations or preferred provider networks to organize specialized mental health and substance abuse treatment for enrollees independently from overall health care. Typically, MBHCOs assign specialist "gatekeepers" to assess and monitor clients' need for access to and utilization of treatment within the network (ASAM [American Society of Addiction Medicine], 1999). Most individuals with private insurance have their behavioral health care needs met by some type of MBHCO (Schoenbaum, Zhang & Sturm, 1998).

Managed care presents challenges for all behavioral health care providers and particularly

so for those targeting LGBT individuals, because LGBT concerns are not well understood by—or even visible to—the leadership of managed care organizations.

The specific needs of LGBT individuals are not well understood by managed care organizations (MCOs). Moreover, few LGBT health care consumer organizations have overtly voiced the specific needs and concerns of this multicultural group. LGBT individuals, especially LGBT persons of color, thus remain hidden, neither accessing the health care system nor communicating honestly with health care providers—all of which has deleterious consequences for LGBT individuals needing treatment services. Clearly, providers of services to LGBT populations have much to gain by working together to make the case for improved services. Fortunately, there are many groups attempting not only to make LGBT concerns visible to managed care administrators but also to deliver improved services.

Designing and implementing successful treatment practices requires knowledge of the target populations. Thus, the critical need for administrators is to understand the existence of these subpopulations and to invite different LGBT populations to participate in the design of services and polices. Acknowledging this diversity and building appropriate mechanisms for consumer input will enhance the probability of successful treatment.

Why should a managed care and a clinical program consider a partnership between an LGBT program (LGBT-sensitive) and managed care? Managed care has recharged consumerism and awakened the health care delivery system to the requirement of providing access and quality services to an enrolled population in a culturally and linguistically appropriate manner (Kennedy, 1999). Some LGBT consumers or clients or patients (whatever terminology individuals wish to use in their self-identification) and LGBT health care providers are highlighting the needs of these constituencies to be taken care of in an appropriate and professional manner. However, in so doing, consumers risk not only antigay bias but also the stigma of identifying predisposing health conditions, such as HIV/AIDS, addictive diseases, and mental disorders, that may alter benefits packages dramatically.

Another difficulty is that LGBT-identified persons can be seen as "high-cost-of-care" populations. Although data are not available to support or refute this supposition, several reasons can be suggested for the possibility of increased costs. First, managed care seeks to limit the number of patient visits and shorten the length of visits. As a result, a trustful provider/patient relationship may not develop and, therefore, disclosure of a person's sexual orientation or sexual identity may not occur. The lack of this vital information may reduce the likelihood that appropriate care is provided in a timely fashion, thereby potentially raising its cost. Finally, some insurance companies have taken steps to reduce the probability of insuring an individual who may someday contract HIV (Li, 1996).

LGBT providers are also in a precarious position—self-disclosure may result in their exclusion from provider networks. The American Association of Physicians for Human Rights (now Gay and Lesbian Medical Association) (1994) found that 17 percent of self-identified gay and lesbian physicians had been fired, refused medical privileges, or denied employment because of their sexual orientation.

Despite the experiences of LGBT consumers and providers, incentives exist for MCOs to provide LGBT-sensitive services. It can be advantageous to a managed care company to attract business. Similarly, competent LGBT providers enhance the managed care company's panel of providers and also satisfy the cultural and ethnic competency standards

articulated in some States' Behavioral Health Request for Proposal (RFP) (e.g., Iowa Substance Abuse RFP, pp. 30–17).

Concerns About Managed Care Organizations

As managed care increasingly dominates both private and public sector mental health and substance abuse treatment services, serious concerns have been expressed by key stakeholders about whether managed care financing, if not properly administered, might in fact cause greater disparities than the fee-for-service system in meeting the critical needs of individuals with behavioral problems.

Their specific concerns include the following (Surles & Fox, 1998):

- Cost-cutting, which potentially threatens the quality of care
- Restructuring of services away from local, community-based approaches
- Relocation of services, which threatens accessibility
- Services provided to consumers by mental health professionals not familiar with the language, cultural values, and multiple needs of different groups
- Consumers' lack of knowledge about how the managed care system works
- Language differences that interfere with communication and access to resources.

Professional guidelines, consumer report cards, and accrediting organizations are mechanisms that ensure provision of culturally competent health care services. Attention or inattention to cultural issues impacts both service delivery and service utilization that, in turn, affect not just quality, access, and utilization, but also costs. There would likely be an improvement in the utilization of services if policies, procedures, and guidelines addressed the unique cultural issues of consumers and providers (Lu, 1996).

Within the Federal Government, the Health Care Financing Administration is in the process of developing standards (1998) within its Quality Improvement System for Managed Care to include a statement that speaks to nondiscrimination for managed care enrollees based on sexual orientation.

The two largest accreditation bodies for managed care organizations are the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations. Neither organization has yet issued professional standards of practice related to the treatment of LGBT individuals, nor has either developed standards or quality measures regarding treatment of LGBT individuals that managed care organizations would be required to meet. Thus, for the consumer member of a managed care plan, whether public or private, there is no single requirement to ensure nondiscrimination based on sexual orientation.

Beyond one very specific project in Massachusetts (see the case example following), other "position" or "issue" statements can be found within several of the national associations that represent mental health practitioners. For example, the National Association of Social Workers (NASW) has developed a Policy Statement (1996) that articulates its position that a same-gender sexual orientation should be afforded the respect and rights given an other-gender orientation. NASW also supports curriculum policies in schools of social work that eliminate discrimination against lesbian, gay, and bisexual people and encourage the implementation of continuing education programs on practice and policy issues

relevant to lesbian, gay, and bisexual people and cultures, as well as human sexuality.

The American Psychiatric Association (APA) has, since 1974, affirmed that certain sexual orientations are not a mental illnesses and has removed this diagnosis from all subsequent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The practice guidelines APA issued in 1995 prohibited specific discrimination against gay and lesbian clients (1995). In 1997, the American Psychological Association (in press) adopted a Resolution on Appropriate Therapeutic Responses to Sexual Orientation. In affirming a set of 13 principles, the American Psychological Association officially opposes portrayals of LGBT persons as mentally ill because of their sexual orientation and supports the dissemination of accurate information about sexual orientation and mental health and appropriate interventions in order to counteract bias that is based on ignorance or unfounded beliefs about sexual orientation.

A cursory review of key managed care stakeholders identified a significant number of professional associations, provider groups, private and public purchasers, accrediting groups, and others in a position to affect or advocate policy changes that specifically include **sexual orientation** or **sexual identity** as an important issue relative to clients and providers, including the following:

- Academy of Managed Care Pharmacy
- Addiction Prevention and Recovery Administration, Washington, DC
- American Medical Association Council on Scientific Affairs
- American Medical Student Association
- American Counseling Association
- Cambridge Preferred Provider Network of New York
- Council for Accreditation of Counseling and Related Educational Programs
- Employee Assistance Professional Association
- National Association of Alcoholism and Drug Abuse Counselors
- Patients' Bill of Rights
- Pacificare of California
- Seattle-King County (WA) Department of Public Health
- Waukesha (WI) Memorial Hospital, Health System and Health Care, Inc.

In addition, the American Federation of State, County and Municipal Employees (AFSCME) continues to work to promote the rights of its lesbian and gay union members via the promotion of legislation that affects domestic partner benefits and to oppose discrimination based on HIV status. AFSCME has also issued a report (1994) resulting from its Presidential Advisory Commission that clearly states consumer rights issues within managed care. The Gay and Lesbian Medical Association's (GLMA's) recent policy (1998) "strongly urges HMOs [health maintenance organizations], PPOs [preferred provider organizations], and other managed care organizations to identify and provide referrals to providers with competence in LGBT health so that optimal patient care can be rendered to LGBT people."

Advocacy Efforts and Partnerships To Improve LGBT Care

No study or organized body of literature exists documenting the success or failure of managed care relationships formed between LGBT-focused programs and MCOs. What is known is that some MCOs and many LGBT providers are reaching out to one another to improve care for LGBT individuals. Some examples are listed below, and contact information is provided in the box at the end of the chapter.

- In researching written information from managed care organizations that indicated a sensitivity to LGBT competency, some clearly stated language was found within the body of a proposal of one managed care organization stating that it will apply cultural competency standards and be "sensitive to diversity brought about by a variety of factors including ethnicity, language, lifestyle, age, sexual preference and socioeconomic status." This proposal is to manage behavioral health care for a public sector county-based contract.

- More than 14 MCOs have formed contractual relationships for primary physical health care services with the new Lambda Medical Group in Los Angeles (Jean, 1998). The major insurance plans accepted by it include Blue Cross, CIGNA, Medi-Cal, and MediCare. The Lambda Medical Group expects to serve 4,400 patients per year.

- In Washington, D.C., The Lambda Center, with its comprehensive continuum of inpatient, partial hospitalization, and outpatient services that have been made available via a joint-venture partnership, has been highly successful in attracting the attention of MBHCOs and other MCOs in the Mid-Atlantic region. Contracted rates with more than 10 MCOs have been established for The Lambda Center's acute care services (inpatient hospitalization, detoxification, ambulatory detoxification, partial hospitalization, and intensive outpatient programs), and future plans will include contractual arrangements with a therapist network for the outpatient services component of the continuum. Part of the success is due to a full-scale LGBT-sensitivity and -competency training and education campaign for MCO case managers and senior staff of the MCOs that is being conducted by The Lambda Center in collaboration with the Lesbian Health and Wellness Network (LHWN).

- LHWN, also based in Washington, D.C., is working closely with District of Columbia public sector programs through the Addiction Prevention and Recovery Administration, the D.C. Public Benefits Corporation, the Women's Health Initiative, and the District of Columbia's Medicaid program to incorporate training programs in the District's managed behavioral health care readiness program. In addition, LHWN will be integrally involved in further network expansion efforts, and the LHWN network of providers will actually be listed in the provider directories as a block of lesbian-competent providers.

- The Pride Institute, founded in Minneapolis, Minnesota, began as a residential treatment facility for gay men and lesbians. Today, the Pride Institute manages mental health and addiction programs for LGBT individuals in several cities, including Fort Lauderdale, Chicago, Minneapolis, and New York, and in the Dallas area. Admission to Pride Institute programs is offered through a nationally advertised toll-free number. It is one of the only programs for LGBT individuals with a long-term residential treatment component; these components are based in Minnesota and Fort Lauderdale.

- ALTERNATIVES, founded in 1998, offers a dual diagnosis program for LGBT communities in Los Angeles and, now, in the

San Francisco Bay area. Similar to the Pride Institute, ALTERNATIVES contracts with hospitals to manage and staff separate inpatient units for gay men and lesbians.

LGBT Provider Networks

With the advent of managed care panels, individual providers (e.g., physicians, nurse assistants, social workers, and psychologists) may join those panels to satisfy contractual specifications negotiated with private or public purchasers. In addition, many MCOs allow practicing groups to join. Thus, different specialty networks have formed, which then collectively apply to the different MCOs in the area for enrollment in the MCO panels. Some providers affiliated with LGBT clinics have created networks that provide either MCOs or managed care panels with a cadre of providers with expertise in the treatment needs of LGBT individuals.

A variety of LGBT provider networks have formed throughout the United States. The networks are at varying levels of sophistication in developing relationships with MCOs. Examples of these provider networks are noted below.

- The Gay, Lesbian, Bisexual, Transgender Psychotherapist Association of the Greater San Francisco Bay Area is a nonprofit group of more than 175 LGBT psychotherapists covering the Bay area in California. GAYLESTA, as it is called, has developed a referral service, educational programs, peer consultation groups, a speakers' bureau, a newsletter, and a prelicensed psychotherapist committee. GAYLESTA has also prepared a referral directory that is available to the public.
- The Lesbian Health and Wellness Network is a 150-member provider network based in Washington, D.C., but with members in some States. In addition to the creation of a provider manual and a referral system, this network is actively involved in providing LGBT-competency training for mainstream providers.
- The Los Angeles Lambda Medical Group is a medical center connected to the L.A. Gay & Lesbian Community Center that provides primary and preventive health care by physicians who specialize in the health care needs of lesbians and gay men.
- The Lambda Center and Therapist Network is an LGBT-specific continuum of inpatient and outpatient mental health and addictions services in Washington, D.C., that was begun by the Whitman-Walker Clinic and The Psychiatric Institute of Washington (a psychiatric hospital). The formation of a far-reaching provider network in the Baltimore-Washington area has recently been formalized.
- Fenway Behavioral Health Services in Boston is a program for gay men diagnosed with mental health and addiction problems, based in the Fenway Gay/Lesbian Community Center. Referrals are made to a network of therapists.

Substance abuse treatment programs have many potential allies. Identifying and working with these allies is extremely important, particularly in building community support for LGBT services and in successfully navigating the managed care environment.

Case Example

The Lesbian, Gay, Bisexual, and Transgender Health Access Project, a collaborative community-based program funded by the Massachusetts Department of Public Health, Boston, Massachusetts, has developed Community Standards of Practice for Provision of Quality Health Care Services for LGBT clients. The project's mission is to foster development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care services for lesbian, gay, bisexual, and transgender people and their families.

Working closely with consumers and clinicians across Massachusetts, the LGBT Health Access Project works to confront the insensitivity and ignorance that many LGBT individuals have experienced in accessing health care and related services. Additionally, the project works to support LGBT individuals in understanding and acquiring the quality care they need. The Community Standards of Practice is the outcome of this work and was developed to provide a benchmark for both providers and consumers in the development of and search for welcoming, culturally competent, and responsive care.

The Community Standards of Practice and quality indicators are meant to guide and assist providers in achieving a set of goals that include:

- The elimination of discrimination on the basis of sexual orientation and gender identity
- The promotion and provision of full and equal access to services
- The elimination of stigmatization of LGBT people and their families
- The creation of health service environments where it is safe for people to be "out" to their providers.

The standards address both agency administrative practices and service delivery components, including the following areas:

- Personnel
- Client's rights
- Intake and assessment
- Service planning and delivery
- Confidentiality
- Community outreach and health promotion.

There are 14 standards in all, accompanied by appropriate indicators for each standard. (The standards can be accessed via the Internet at www.glbthealth.org.)

Advocates for LGBT-Specific Health Care Services

Gay and Lesbian Association of Retiring Persons, 310–966–1500
Gay & Lesbian Issues Committee/Employee Assistance Professionals Association, 703–522–6272
Gay and Lesbian Medical Association (GLMA), 415–255–4547
Gay, Lesbian, Bisexual Employees of the Federal Government, 202–543–9583
Human Rights Campaign, 202–638–4160
Kaiser Permanente Pride, 510–987–4148
National Association of Lesbian & Gay Addiction Professionals (NALGAP), 703–465–0539
National Latina/o Lesbian, Gay, Bisexual & Transgender Organization, 202–466–8240
National Lesbian & Gay Nurses Association, 718–933–1158
Parents, Families and Friends of Lesbians and Gays, 202–638–4200

LGBT Health Care Providers and Behavioral Health Care Programs Serving LGBT Clients

Alternatives — Los Angeles & San Francisco, CA, 800–342–5429
Callen-Lorde Community Health Center — New York, NY, 212–271–7200
Chase Brexton Clinic — Baltimore, MD, 410–837–2050
Health Initiatives for Youth (HIFY) — San Francisco, CA, 415–487–5777
Fenway Community Center — Boston, MA, 617–267–0900
Hartford Gay & Lesbian Health Collective — Hartford, CT, 860–278–4163
L.A. Gay & Lesbian Center — Los Angeles, CA, 213–993–7400
New Leaf Services — San Francisco, CA, 415–626–7000
Pride Institute, Minneapolis, MN, 800–54–Pride
Project Connect — New York, NY, 212–620–7310
Stepping Stone — San Diego, CA, 619–543–1346
Stonewall Recovery Services — Seattle, WA, 206–461–4546
The Lambda Center — Washington, DC, 877–2LAMBDA
Whitman-Walker Clinic — DC, MD, and VA, 202–797–3500

Chapter 18 Recommendations

This chapter provides recommendations for:

- Additional research needs
- Clinicians on improving treatment for LGBT clients
- Improving training about LGBT issues
- Administrators on improving treatment for the LGBT community
- Managed care, program planning, and quality assurance

Introduction

Lesbian, gay, bisexual, and transgender (LGBT) individuals are entitled to services provided in a safe and appropriate environment and should not be denied services based on their sexual orientation. The treatment provided should be sensitive to and supportive of the unique needs of the client. Therefore, substance abuse treatment providers, counselors, therapists, administrators, and facility directors need to become aware of the issues facing LGBT clients. With this knowledge, they can design quality treatment programs that provide effective, ethical, and informed care for LGBT clients. This improvement in care will improve outcomes for LGBT clients, and treatment providers will reach a previously underserved population.

Recommendations for Research

LGBT populations abuse substances at rates that are the same as or higher than the rates in the general population, but more information is needed in this area. Future studies should create a clearer distinction between substance use and substance abuse, employ more vigorous sampling methodology, establish prevalence and incidence rates for the specific substances of abuse, and identify the effects that age, sexual identity, discrimination, and heterosexism have on substance use and abuse among LGBT individuals. In addition, substance abuse among lesbians, bisexual

women, and transgender individuals should be further studied and substance abuse among them distinguished from substance abuse among gay and bisexual men.

Innovative LGBT-specific intervention and treatment approaches are needed and should be researched and developed. Health care providers and delivery systems should develop new models of intervention and treatment targeted especially to LGBT individuals. Researchers, government agencies, and community-based organizations should work together to create innovative outreach efforts, prevention campaigns, and standards of treatment for LGBT individuals.

LGBT-identified researchers, scientists, and consumers should be included in public health policy formulation and resource decision matters related to substance abuse prevention and treatment.

Recommendations for Clinicians

To provide quality care for LGBT clients, treatment providers need to learn about sexual orientation and gender identity and how these are determined. Counselors need to know more about how LGBT individuals learn to acknowledge and accept their sexual orientation, about the stages of coming out, and about how to meet the needs of clients, regardless of sexual orientation. Counselors can help LGBT clients recover from substance abuse and addiction by being empathic, supportive, and nonjudgmental and assisting clients to:

- Integrate their sexual identity
- Become more self-accepting
- Heal from shame resulting from heterosexism, internalized homophobia, and substance abuse.

The counselor should help the recovering LGBT individual connect with a community that will help him or her heal, such as 12-step or other self-help groups, other LGBT individuals in recovery, and the client's own family of choice. The counselors should learn to provide sensitive support for LGBT clients' families and partners.

Counselors should remember that LGBT clients may have additional health concerns such as co-occurring mental illnesses, HIV/AIDS, STDs, liver disease, hormone-related issues, and hepatitis B or C. Counselors should screen for other health problems and for domestic violence. Any assessment should be framed with sensitivity.

Counselors must confront their own negative or ambivalent feelings about homosexuality and learn to provide quality care that is sensitive, supportive, and comprehensive.

It is a challenging task to provide services that are appropriate, accessible, cost-effective, and quality driven. The following section includes selected recommendations for achieving this goal.

- Counselors and treatment providers need to reexamine their treatment approaches and take steps to move them to LGBT-sensitive and supportive modalities.
- Internalized homophobia, anti-LGBT bias, and heterosexism may contribute to the use of alcohol and drugs by LGBT individuals. Providers should learn the effects of these negative biases on the LGBT individual and community and how to help LGBT clients affirm themselves and address negative feelings. A better understanding is needed of the interplay between sexual orientation and the sociocultural context in relation to substance use, abuse, and treatment.
- Treatment providers should learn about substance abuse in the LGBT community. Substance use, especially alcohol, is often an integral part of the LGBT social life and

is connected to sexual identity formation, coming out, and self-acceptance processes for many LGBT persons.

- Treatment providers should work at the individual client's comfort level related to his or her sexual orientation issues and consider how the client's feelings about his or her sexual orientation affect the client's recovery.

- All staff and clients should not assume that stereotypes and myths about LGBT individuals are true. Each LGBT individual is unique.

Recommendations for Training

A limited number of facilities offer LGBT-sensitive treatment. The training of professional and support staff to serve LGBT individuals in their own communities is critical for improving treatment and treatment outcomes. Considerations for improving training to enhance treatment for the LGBT community follow.

- Provide training to staff members in cultural diversity and sexual orientation sensitivity to promote better understanding of LGBT populations. Education topics should be diverse and applicable to all LGBT populations and include topics of sexual orientation, sexual identity, gender, and sexual behaviors.

- Use LGBT-specific training and educational programs to ensure that quality care is provided. Educators and trainers with expertise in LGBT issues should develop training programs, manuals, books, videos, films, CD-ROMS, and other interactive training technology focused on LGBT treatment that can be widely disseminated.

- Provide sensitivity training when LGBT clients and heterosexual clients attend the same group therapy sessions. Counselors should protect LGBT clients from homophobic behavior. LGBT clients should not be forced to discuss sexual orientation or behaviors if they are not comfortable doing so. If the facility provides LGBT-only groups, attendance should be voluntary and confidentiality should be respected.

- Assess staff comfort, experience, and competence in serving LGBT individuals before developing a training program, during training, and after providing training.

Recommendations for Administrators

Managed Care

Managed care and other health care provider networks should strive to improve their LGBT sensitivity.

- Managed care organizations' (MCOs') panels of providers should include LGBT providers and LGBT-sensitive providers.

- LGBT medical and professional organizations should request that MCOs include LGBT providers and an LGBT category as a recognized subgroup of the health insurance plan.

- Managed behavioral health care organizations should be able to inform case workers of subcategories of providers; for example, a caseworker should have enough information to be able to refer a client to substance abuse treatment services that are identified as LGBT sensitive.

- LGBT programs should join other networks to ensure culturally competent services.

- Service purchasers such as MCOs, health maintenance organizations, and employee assistance programs should identify and use resources for providing culturally competent substance abuse treatment services to LGBT clients.

Program Planning

- Program administrators, counselor training program directors, and substance abuse treatment educators should encourage planning for and implementation of training programs to serve substance-abusing LGBT clients.

- Once an LGBT-sensitive program is established, providers should develop programs for drugs such as cocaine, crack, methamphetamine, and other addictive drugs that are challenging to treat.

Quality Assurance

To ensure high-quality treatment:

- Providers should evaluate their programs. They should collect appropriate demographic data to establish baseline information about LGBT clients. They should design and implement appropriate client satisfaction measures that provide specific feedback about how well the organization is serving LGBT clients.

- Community services personnel, professional associations, and others engaged in training mental health and social work professionals and support staff should review and revise their existing policies to reflect LGBT needs.

- Service providers should review policies and procedures to improve sensitivity toward and effectiveness in serving LGBT clients.

- Providers should develop better LGBT-specific outcome data. They should compare the numbers of clients served, overall satisfaction results, and treatment outcomes among identified LGBT clients with data pertaining to the general treatment population.

- Providers should consult with persons with expertise in LGBT issues, such as clients, staff, advocacy groups, or organizations, to provide assistance in developing an LGBT program that is sensitive, supportive, and effective.

- Providers should promote application of standards by accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, and the Commission for the Accreditation of Rehabilitation Facilities to specifically acknowledge and address the needs of LGBT individuals and provide appropriate education for surveyors from these bodies. Treatment accreditation bodies should mandate demonstrated proficiency in LGBT health and safety issues.

It is hoped that this volume will assist administrators and clinicians in forming a better understanding of LGBT people, their problems with substance abuse, and the unique challenges they face and that the knowledge gained about designing programs for LGBT clients will be used to create a more comfortable environment for LGBT clients.

SECTION IV:
APPENDIXES

Appendix A Glossary of Terms

The following terms are meant to guide the reader by providing clarity. However, it should be noted that some of the definitions continue to evolve over time as language changes from generation to generation.

Acculturation—Accommodation to the rules and expectations of the majority culture without giving up cultural identity entirely.

Ageism—Discriminatory behavior relating to age.

Assimilation—Adaptation to a new culture by taking on a new identity and abandoning the old cultural identity.

Biphobia—Irrational fear and dislike of bisexuals.

Bisexual—Man and woman with a sexual and affectional orientation toward people of both genders.

Circuit Party—Weekend dance party usually attended by urban gay males. These parties typically occur on a holiday weekend, and just as with many dance clubs and bars, many of their patrons are involved in substance use and abuse.

Coming Out—Individual and personal process by which a person accepts his or her homosexual or bisexual orientation and transforms it from a negative to a positive thing in a culture that is homophobic and does not validate and affirm diversity and difference. It is a process of healing from homophobia and heterosexism and taking on a positive identity. It may include sharing this process and its outcome with others or it may be private.

Confidentiality—Restriction against disclosure to certain persons or institutions of medical or personal information about a client without his or her consent.

Co-occurring Disorders—Condition in which a person has more than one disorder or disease.

Countertransference—Process of counselors seeing themselves in their clients, overidentifying with their clients, meeting their own personal needs through clients, or reacting to a client because of unresolved personal conflicts.

Cultural Competence—Broad-based and diverse understanding of, and ability to respond and relate to, culturally specific nuances, communication styles, traditions, icons, experiences, and spiritual traditions of a given culture or cultures.

Denigrate—To cast aspersions on, to defame, or to deny the importance or validity of something or someone.

Dysphoria—State of feeling unwell or unhappy.

Epidemiology—Incidence, distribution, and control of disease in a population.

Family of Choice—Persons an individual sees as significant in his or her life. It may include none, all, or some members of his or her family of origin. In addition, it may include individuals such as significant others or partners, friends, coworkers, etc.

Family of Origin—Birth or biological family or any family system instrumental or significant in an individual's early development.

Gender Identity—Sense of oneself as male or female. As a comparison, a person may be born biologically male yet have a female gender identity.

Hermaphrodite—A person born with both male and female reproductive organs.

Heterosexism—Value and belief that heterosexuality is the only "natural" sexuality and that it is inherently healthier than or superior to other types of sexuality. Heterosexism is the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community.

Heterosexuals—Term used to describe those individuals with a primary sexual and affectional orientation toward persons of the opposite gender. Heterosexuals are often referred to as straight.

Holistic—Consideration of the entire individual (physical, intellectual, emotional, spiritual, and environmental).

Homophobia—Irrational fear or dislike of homosexuals. This includes the discomfort and dislike that some heterosexuals have toward lesbian, gay, bisexual, and transgender individuals.

Homosexual—Term used to describe an individual with a primary sexual and affectional orientation toward persons of the same gender. Male homosexuals are often referred to as gay, whereas female homosexuals are referred to as lesbians.

Internalized Homophobia—Accepting and believing the negative messages of the dominant group as they relate to gay men and lesbians; the internalized self-hatred that gays and lesbians struggle with as a result of heterosexual prejudice.

Life Cycle—Stages of development (infancy, childhood, adolescence, young adult, adult, elder).

Lookism—Prejudice that some people harbor based on a limited and narrow definition of what physical traits are desirable.

Methamphetamine—Powerful central nervous system stimulant. A synthetic drug that has a high potential for abuse and dependence. It is illegally produced and sold in pill form, capsules, powder, and chunks. Methamphetamine was developed early in this century from its parent drug amphetamine and was originally used in nasal decongestants, bronchial inhalers, and the treatment of narcolepsy and obesity. In the 1970s, methamphetamine was classified a Schedule II drug—a drug with little medical use and a high potential for abuse.

Next of Kin—Person or persons designated in case of emergency. Traditionally this designation has been used only for immediate family of origin or married partners.

Nonoperative—The status of a transsexual individual who will not undergo sex reassignment surgery. Also called non-op.

Out or Out of the Closet—Refers to varying degrees of being open about one's homosexual or bisexual orientation.

Passive Partner—Term frequently used in reference to male-to-male sexual behavior, specifically the receptive partner during sexual intercourse.

Postoperative Person—Transsexual who has completed gender reassignment surgery.

Power of Attorney—Legal document in which one person authorizes another person to act on the former's behalf.

Preoperative Person—Transsexual who is contemplating gender reassignment surgery.

Quality Improvement Program—A systematic effort undertaken by an organization to analyze processes and procedures and identify and implement changes in order to achieve more desirable outcomes.

Rave—Type of dance party at which many of the patrons are involved in substance use and abuse.

Ryan White Care Act—Federal legislation that authorizes funding for the support of people with HIV/AIDS.

Seropositive—Serotype that suggests someone has experienced infection in the past.

Sex Industry Workers—Individuals (either male or female) who work as prostitutes, hustlers, or escorts and are in the business of providing sex for money, drugs, or housing.

Sexual Harassment—An illegal act that occurs in a place of employment when one person inflicts on another conversations or actions of a sexual nature. This behavior can either involve the condition of concrete employment benefits for sexual favors or create a hostile or offensive working environment for those involved and can be grounds for legal recourse.

Sexual Identity or Orientation—The erotic, physical, and emotional attraction to members of one's own gender, the opposite gender, or both genders and one's conscious or subconscious decision to define and label this affinity and attraction.

Significant Other—A life partner, domestic partner, lover, boyfriend, or girlfriend. Because gays and lesbians still are not allowed to be legally married in the United States (although they are allowed to in some European countries), significant other is equivalent to the term "spouse."

Sodomy Laws—State statutes (which vary by State) that prohibit contact between the mouth or anus of one person and the sexual organs of another person (consensually or otherwise).

Synthesis—Combining of often diverse conceptions into a coherent whole.

Transference—Redirection of feelings and desires.

Transgender Person—One whose gender identity is not congruent with his or her biological gender, regardless of the status of surgical and hormonal gender reassignment processes. Sometimes used as an umbrella term encompassing transsexuals, transvestites, cross dressers, and others. The term transgender refers to a continuum of gender expressions, identities, and roles, which expand the current dominant cultural values of what it means to be female or male.

Transphobia—Irrational fear or dislike of transgender individuals.

Transsexual—Individual with biological characteristics of one sex who identifies himself or herself as the opposite gender. There are female-to-male and male-to-female transsexuals: Transsexuals usually desire to change their bodies to fit their gender identities and do this through hormone treatment and gender reassignment surgery.

Treatment Readiness—Stage or phase that an individual may be in related to changing alcohol and drug use activities (i.e., decrease harmful alcohol- and drug-related behaviors).

Appendix B References

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Appendix C Acronyms

AA	Alcoholics Anonymous
ACLU	American Civil Liberties Union
ACOA	Adult Children of Alcoholics
ADA	Americans with Disabilities Act
ADM	alcohol, drug abuse, and mental health
AFSCME	American Federation of State, County, and Municipal Employees
AIDS	acquired immunodeficiency syndrome
AMBHA	American Managed Behavioral Healthcare Association
APA	American Psychiatric Association
API	Asian/Pacific Islanders
ASI	Addiction Severity Index
CARF	The Rehabilitation Accreditation Commission
CDC	Centers for Disease Control and Prevention
CEU	continuing education unit
CMA	crystal methamphetamine
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
EAP	employee assistance program
ERISA	Employment Retirement Income Security Act
FFS	fee-for-service
FTM	female-to-male
GHB	gamma hydroxybuturate
GID	gender identity disorder
GLMA	Gay and Lesbian Medical Association
HEDIS	Health Plan Employer Data and Information Set
HIV	human immunodeficiency virus
HMO	health maintenance organization
IDU	injection drug user/intravenous drug user
IOM	Institute of Medicine
IPA	Individual Practice Association
ITA	It's Time America!
IV	intravenous
JAMA	*Journal of the American Medical Association*
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LGBT	lesbian, gay, bisexual, and transgender
LHWN	Lesbian Health and Wellness Network
MAP	member assistance program
MAST	Michigan Alcohol Screening Test
MBHC	managed behavioral health care
MBHCO	managed behavioral health care organization

MCO	managed care organization
MSM	men who have sex with men
MTF	male-to-female
NA	Narcotics Anonymous
NAADAC	National Association of Alcohol and Drug Abuse Counselors
NALGAP	National Association of Lesbian and Gay Addiction Professionals
NASW	National Association of Social Workers
NCQA	National Committee for Quality Assurance
NGLTF	National Gay and Lesbian Task Force
NHSDA	National Household Survey on Drug Abuse
NIDA	National Institute on Drug Abuse
OAS	Office of Applied Studies
ONDCP	Office of National Drug Control Policy
PAWS	postacute withdrawal syndrome
PCCM	primary care case management
PFLAG	Parents, Families and Friends of Lesbians and Gays
PHO	physician hospital organization
PMS	premenstrual syndrome
POS	point of service
PPO	preferred provider organization
PSA	public service announcement
PSN	provider-sponsored network
PSO	provider-sponsored organization
QISMC	quality improvement system for managed care
RCD	Resource Center of Dallas
RET	rational-emotive therapy
ROTC	Reserve Officers' Training Corps
RWJF	Robert Wood Johnson Foundation
SAMHSA	Substance Abuse and Mental Health Services Administration
SASSI	Substance Abuse Subtle Screening Inventory
STD	sexually transmitted disease
TAP	Technical Assistance Publication
TIP	Treatment Improvement Protocol
WWATS	Whitman-Walker Clinic, Inc., Addiction Treatment Services

Appendix D Studies on LGBT Substance Abuse

Study	Study Population	Substance Use/Abuse	Methodology	Comparison Group	Outcome	Comments on Outcome
Saghir et al., 1970[1]	Lesbians N=200	Alcohol	Convenience sample	None	33% reported having a problem with alcohol	No comparisons can be made at this time
Fifield et al., 1977[1]	Lesbians N=57	Alcohol	Convenience sample	None	35% reported having a problem with alcohol	No comparisons can be made at this time
Lewis et al., 1982[1]	Lesbians N=57	Alcohol	Convenience sample	None	28% reported having a problem with alcohol	No comparisons can be made at this time
Morales & Graves, 1983[1]	Lesbians N=129	Alcohol	Convenience sample	None	27% reported having a problem with alcohol	No comparisons can be made at this time
Bradford & Ryan, 1987[1]	Lesbians N=1,917	Alcohol	Population-based (National Lesbian Health Care Survey)	None	6%—daily drinkers 25%—drink 1+/wk 30%—drink 1+/mo 17%—abstainers	No comparisons can be made at this time
Stall & Wiley, 1988	Gay men	Alcohol & drugs	Population-based (San Francisco Men's Health Study)	Heterosexual men in San Francisco		Gay men had greater substance use (excluding alcohol) than heterosexual men
McKirnan & Peterson, 1989[1]	Lesbians N=748	Alcohol	Convenience sample	General population women (Clark & Midinak, 1992[1]	76% vs. 59%—Moderate 9% vs. 7%—Heavy 23% vs. 8%—Problems	Lesbians had greater alcohol use than general population women
Bloomfield, 1993[1]	Lesbians N=58	Alcohol	Convenience sample	Heterosexual women (N=397)	69% vs. 74%—Moderate 11% vs. 10%—Heavy 13% vs. 3%—In recovery 20% vs. 16%—Abstainers	Lesbians had greater alcohol use than heterosexual women

Study	Study Population	Substance Use/Abuse	Methodology	Comparison Group	Outcome	Comments on Outcome
Skinner, 1994	Lesbians & gay men	Alcohol, cigarettes, marijuana & other illegal drugs	Convenience sample	Heterosexuals		Lesbians & gay men had greater substance use than heterosexuals
Skinner & Otis, 1996[1]	Lesbians N=500	Alcohol	Convenience sample	General population women N=725	32% vs. 28%—1-4 drinks/mo 26% vs. 11%—5-19 drinks/mo 12% vs. 2%—20-30 drinks/mo 28% vs. 9%—5+ drinks/occasion	Lesbians used more alcohol than general population women
Hughes et al., 1997	Lesbians N=284	Alcohol or drug problems	Convenience sample	Heterosexual women N=134	10% vs. 2% 77% vs. 85%—Light/moderate 2% vs. 2%—Heavy 19% vs. 13%—Alcohol problems	Lesbians used more substances than heterosexual women
Clements et al., 1998	Transgender persons (N=515)	Intravenous drug use	Convenience sample	None	34% MTF w/lifetime IV drug use 18% FTM w/lifetime IV drug use	No comparisons can be made at this time
Woody et al., 1999	Men who have sex with men (MSM) and are at specific risk for HIV/AIDS (N=3,212)	Alcohol, nitrite inhalants, hallucinogens, stimulants, sedatives, tranquilizers, marijuana, cocaine	Convenience sample	General population men	This nongeneral sample of MSM who were specifically at risk for contracting HIV disease was 21 times more likely to use nitrite inhalants, 6 times more likely to use hallucinogens, 4 times more likely to use stimulants, 7 times more likely to use sedatives, and 5 times more likely to use tranquilizers	MSM used more substances than general population men
Cochran & Mays, 2000	Same gender (male) partners (N=98) Same gender (female) partners (N=96)	Alcohol dependence (DSM–IV) Drug dependence (DSM–IV)	Population-based (1996 National Household Survey of Drug Abuse)	Opposite-gender (female) partner(s) only (N=3,922) Opposite-gender (male) partner(s) only (N=5,792)	10% of males with partners of the same gender vs. 7.6% of males with partners of the opposite gender exhibited symptoms of alcohol dependence. 7% of females with partners of the same gender vs. 2% of females with partners of the opposite gender exhibited symptoms of alcohol dependence. 5.7% of males with partners of the same gender vs. 2.8% of males with partners of the opposite gender exhibited symptoms of drug dependence. 5% of females with partners of the same gender vs. 1.3% of females with partners of the opposite gender exhibited symptoms of drug dependence.	Same-sex partners used more substances than opposite-sex partners

Study	Study Population	Substance Use/Abuse	Methodology	Comparison Group	Outcome	Comments on Outcome
Cochran et al., in press	Same gender partners (gay and lesbian) (N=194) Opposite gender partners (N=9,714)	Alcohol dependence (DSM-IV)	Population-based (1996 National Household Survey of Drug Abuse)	Same gender partner (male) vs. opposite gender partners (male) Same gender partner (female) vs. opposite gender partners (female)	Lesbians were 2 times more likely to use alcohol in the past month, 3.5 time more likely in the past year, 5 times more likely to use alcohol every day, 2.25 times more likely to get intoxicated, and 4 times more likely than heterosexual women to get intoxicated weekly. There were no differences between gay and straight men.	Lesbians were at higher risk for alcohol use than heterosexual women
Welch, Howden-Chapman & Collings, 1998	New Zealand lesbians N=200	Drugs	Survey	None	76% reported using cannabis once (lifetime) and 33% reported use in the last year 31% used recreational drugs other than alcohol and cannabis at some time, and 4.5% reported past year use	No comparisons can be made at this time

[1]As cited in Hughes, T. (November 1999). *Sexual Identity and Alcohol Use. A Comparison of Lesbians' and Heterosexual Women's Patterns of Drinking.* Presentation conducted at the National Institute of Mental Health.